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ABSTRACT

A State Implementation Grant Program (SIG) project coordinated an interagency approach to services for handicapped children, from birth to 3 years of age, in Maryland. A SIG panel was established from representatives of public and private agencies and consumers. The panel first identified existing services for the population (the matrix of services is appended), then noted major problems or issues in providing services (involving child identification, screening, assessment, and training). A symposium on infant services was held, and a needs assessment survey of local schools undertaken. Other activities performed included development of an early childhood concept paper (appended), review of educational materials related to infant services, and efforts to involve other agencies in child find and intervention tasks. Copies of agreements with other agencies are appended. The SIG project resulted in a draft state plan (appended) regarding educational services for handicapped children from birth to age 3 and recommendations for achieving the stated goals and objectives. (CL)

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Final Report

STATE IMPLEMENTATION GRANT

FY 1981

Date of Submission: November 30, 1981

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Maryland State Department of Education

Division of Special Education

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Final Report

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FINAL REPORT

STATE IMPLEMENTATION GRANT

I MAJOR ACCOMPLISHMENTS

A. Introduction

In FY'81, the Maryland State Department of Education was awarded a one-year State Implementation Grant (SIG) from the U.S. Office of Special Education to support planning activities related to educational services for young handicapped children. This grant enabled the Maryland State Department of Education, Division of Special Education, Program Assistance and Development Branch, to initiate the interagency collaborative activity for the development of a comprehensive plan for ensuring quality services for handicapped children 0-3. This mission was especially timely as FY'81 (September 1, 1980) marked the beginning of mandated services to the birth to age three population under COMAR 13A.05.01. Prior to this date, some of the state's 24 local school systems were providing some degree of services to this age group, thus demonstrating local support to the state's commitment to early identification and appropriate special education at the earliest possible time.

The planning process for this project was guided by the working draft of *Comprehensive Statewide Planning: A Reference Guide for Planning Services for Preschool Children with Special Needs* drafted by SIG Project Directors, Handicapped Children's Early Education Program (HCEEP) Technical Assistance Staff, and Federal Project Officers. The following steps were implemented:

Preplanning	- Definition of Problem - Analysis of Problem - Identification of Constraints and Resources for Planning - Securing of Administrative Commitment - Identification of Participants
Plan Development	- Needs Assessment - Problem Consensus - Priorities - Formulated Goals and Objectives - Specify Tasks

The planning process as well as the implementation of this grant was significantly aided by the support, assistance and guidance of selected staff from the Johns Hopkins University.

As the resources available to provide specialized services to this target population varied markedly among the LEAs, the need for the state and key human services delivery agencies to give direction became apparent. School superintendents, directors of special education, state and local school board members, medical social services, and college and university professionals, parents and advocacy groups sought information and clarification of issues regarding the education of handicapped infants. Some of the issues raised are reflective of the embryonic stage of early intervention for handicapped children, and cannot be definitively resolved given the current state of research and knowledge. However, several critical issues were targeted for careful consideration by an interagency consulting group in an attempt to build a framework upon which local school systems could support quality early intervention programs.

B. State Implementation Grant Consultant Panel

The first stage of FY'81 SIG planning activities resulted in the identification of agencies whose functions were considered to have the potential for significant impact on the quality of life and developmental potential of handicapped infants. Key individuals from three specific agencies were selected based on their professional expertise and authorization by the policy making administration of each agency. The state agencies participating were:

Maryland State Department of Education (MSDE).
Maryland State Department of Health and Mental Hygiene (DHMH)
Maryland State Department of Human Resources (DHR)
Maryland State Council for Developmental Disabilities (DDC)

Administrative support was obtained from the directors of these agencies.

The professional background of the participants included special education, regular education, parents, pediatrics, social work, and advocacy. Three representatives of early intervention programs, both public and private were selected. These individuals, representing Anne Arundel County, Cecil County, and Montgomery County (private sector) also brought to the group the disciplines of psychology, special education and speech/language pathology.

Participation from institutions of higher education and the Maryland State Teacher's Association was gained to insure representation by direct services providers (teachers). This provided an additional dimension to the group particularly in the areas of preservice and inservice preparation.

Two families representing parents of handicapped infants also played a valuable part in the composition of this group as knowledgeable consumers of services. These parents receive educational services within their homes from a local education agency.

SIG personnel, headed by the project director, provided coordination to the group and acted under the administrative leadership of the Assistant State Superintendent for Special Education and the Chief, Program Development and Assistance Branch, Division of Special Education.

Other MSDE personnel, including an interagency specialist, an early childhood special education specialist and a specialist in parenting completed the composition of the SIG Consultant Panel.

Full group monthly meetings began in January, 1981 and continued through June, 1981. Additional work sessions of small task forces were scheduled.

The charge of this group, issued by Ms. Martha Irvin, Assistant State Superintendent, Division of Special Education is listed below.

CHARGE:

> Recommendations should focus on handicapped children who have one or more disabilities as defined in P.L. 94-142 and Maryland Bylaw 13.04.01. Specifically, the charge to the Panel was to:

1. Identify possible areas of interagency collaboration, for example, referral, screening, evaluation, and joint service delivery.
2. Develop recommended procedures in the identified areas for serving handicapped children from birth through age two.

This panel will continue to serve this proposed project during FY '82.

C. Development of a Matrix of Services

The first step in the development of a plan was to identify the existing services available in Maryland for handicapped children from birth to age three and their families. Members of the SIG Consultant Panel provided information regarding tyupes of services, eligibility, procedures for accessing, and contact persons. Parents and other consumers provided additional information on agencies and community groups which provided support and assistance for children and their families. Appendix A contains the Matrix of Services developed by the SIG Consultant Panel.

D. Development of a Plan

Numerous steps were taken to set the groundwork for the development of the draft plan. They included:

- clarification of the charge to the SEG consultant Panel,
- Clarification of terminology i.e., special education, handicapping conditions,

- identification of limitations of the SIG Project,
  clarification of Maryland's Bylaw as it relates to educational services for handicapped infants,
- identification of existing educational services for infants in Maryland's 24 local school systems,
- clarification of MSDE commitment to education services or handicapped infants and their families i.e., Child Find Network, Inservice Training, MSDE Early Childhood Staff,
- clarification of the role of non-public schools for the provision of educational services for infants, and
- identification of the state of the art in areas such as teacher training, teacher certification, screening, assessment, program models.

The next major accomplishment was the identification of major problems/issues generic to the provision of educational services to handicapped infants and their families. Some of the problem identified by the panel were:

- need for increased public awareness,
- need for a speedy referral system among agencies,
- need for a system to share health records, test results and progress data among agencies,
- need for a system to track children who were considered to be "at risk",
- need for comprehensive preservice and inservice training of teachers and other school related personnel who work with handicapped infants and their families,
- need for agreements to share the costs for services,
- need for expanded services for potential parents and parents of handicapped infants.

These problems/issues were narrowed to focus on topics which could be addressed by the consultant panel during FY 81, the areas were:

Child Identification
Screening
Assessment
Training

The Consultant Panel with the assistance of staff from the National Association of State Director of Special Education (NASDSE) identified major goals and objetives in the above areas. These goals and objectives were to ultimately result in improved services for handicapped infants and their families. Next, the Panel provided recommended action steps for each objective.

All recommendations were compiled and organized by SIG staff and an intern from the University of Maryland, Department of Special Education. A draft plan was prepared for the consultant Panel copies were also sent to those who were unable to participate as panel members, and to the MSDE Early Childhood - Special Education Consultant Team. Recommended changes were incorporated into the final draft which is found in Appendix ____.

The draft plan will be expanded during FY'82. An effort will be made to pilot portions of the plan in local school systems.

E. Infant Symposium: State of the Art of Services for Handicapped Infants

The Maryland State Department of Education in cooperation with the Johns Hopkins University conducted an "Infant Symposium" on August 13-14, 1981. The purpose of this symposium was to provide a forum for professionals of national, state and local significance to respond to critical issues pertinent to planning and implementing early intervention programs. The following areas were addressed.

Child Identification

Screening

Assessment

Partnerships with Parents

Program Administration

Five consultants were selected to address critical issues identified by the SIG Consultant Panel and the LEA Input Team. Each consultant was required to prepare a paper to be given during the Symposium. SIG staff selected members of the consultant team, LEA representatives and university representatives to respond to the papers during question-answer sessions.

The Symposium was attended by eighty-five participants from state agencies involved in services for young handicapped children and their families, local school systems, private schools, universities, hospitals, health clinics and parents of handicapped infants.

The results of the evaluation data indicated that participants found the conference extremely helpful to their work with young handicapped children and their families.

The papers presented by the consultants as well as the recommendations which were provided during the question-answer session will be published in a proceedings paper. This paper, which is being edited, will be distributed to all participants, supervisors of special education and members of the SIG consultant panel.

II. MAJOR SUPPORTING ACTIVITIES

A. Local Education Agency (LEA) Input Team for Early Childhood Special Education

A meeting of the LEA Input Team was held in February 18, 1981 to review the accomplishments of the SIG, validate the direction of work and make recommendations for the ongoing development of a comprehensive plan and procedures for services for handicapped children from birth to age five.

This panel will continue to serve this proposed project during FY '82.

B. Needs Assessment Survey of Local School Systems

In the Fall of 1981, the Assistant Superintendent for Special Education requested that each LEA be surveyed to determine the nature and scope of services being provided to the birth through age five population, with special attention focused on the birth to three population. The objective of this mission was to gain information concerning the following:

- Referral Process,
- Handicapping conditions represented,
- Services delivery model(s) employed,
- Composition of team (disciplines),
- Numbers served,
- Teaching methodology/curriculum used,
- Frequency/length of service,
- Parent Involvement Components,
- Interagency Collaboration,

Additionally, this visitation served to: (1) identify issues considered to be critical by administrators and direct service providers; (2) identify technical assistance and inservice needs.

Information collected from this activity was used in the selection of major areas of focus for the FY '81 grant period. In addition, this information will be vital to the grant activities for FY '82.

These visitations, conducted by SIG/early childhood personnel in cooperation with MSDE regional administrators, took the form of a structured interview with onsite program observation whenever possible.

The outcome of this comprehensive effort was an inhouse document which assisted SIG and Early Childhood staff in designing strategies to meet identified needs among the local school system, and in determining the focus and parameters of the state plan and procedures.

Several common areas of concern emerged from this needs assessment activity:

1. Need for increase funding to serve 0-3 population
2. LEAs, especially those in nonmetropolitan regions face a serious shortage of appropriately trained personnel.
3. Recruitment and hiring of physical and occupational therapists continues to be a statewide problem.
4. Clarification of screening and assessment procedures for 0-3 population, with appropriate training being provided in the use of identified instruments.
5. Increased communication with medical community to foster complimentary delivery of services.
6. Sharing of information and resources on a regional basis.
7. Assistance in developing expertise in parent training and in building parent/professional partnerships.

C. Early Childhood Concept Paper

SIG and early childhood personnel developed a concept paper addressing some of the characteristics of quality early intervention services and outlining the philosophy and guiding assumptions that underpin the need for this service. This document, is found in Appendix C. Although not all encompassing, this paper does reflect a secure position upholding the parents' right and responsibility to be the primary teacher of his/her handicapped infant and the appropriateness of services rendered to the child in the least restrictive environment. Additionally, the efficacy of early intervention is supported, both in terms of fostering maximum developmental potential and in possible reduction or elimination of services in the later years of education.

D. Review of the Infant Related Materials

To assist with the development of a statewide plan for education services for handicapped infants and their families a variety of educational materials were reviewed. Materials such as books, training manuals, films and test instruments related to the areas addressed in the draft plan were reviewed by the SIG staff.

Select resources were purchased and used in the development of the plan and for the provision of inservice training.

E. TADS Support Activities

The Technical Assistance Development System (TADS) has supported the SIG activities in several ways, both contractual and through numerous informal interactions.

Specifically, TADS has provided:

1. Literature searches concerning the efficacy of early intervention,
2. Information concerning state plans, procedures and guidelines for those states mandating service to the birth to three population,
3. Updated listing of curriculae, media and parent training materials,
4. Assistance with planning and implementing the Infant Symposium.

F. State Interagency Activities

SIG personnel, in collaboration with MSDE staff assumed a leadership role in initiating and supporting a variety of cooperative interagency approaches to Child Find, joint service delivery, and related multidisciplinary training activities. Input from a broad range of agencies involved in the state's service delivery system has resulted in proposed interagency strategies that, when implemented, will result in an increase in appropriate referrals and eliminate duplication in the screening and assessment process.

This comprehensive and coordinated approach to Child Find will ultimately result in joint service delivery. The following are some of the FY '81 activities to be refined during FY '82.

G. Coordinated Health Referral:

There has been a need for an increase in participation by health and family related programs in the development and implementation of Child Find activities for handicapped children beginning at birth. Various health related agencies, particularly local health departments, hospital neo-natal programs, and the school nurse program, have begun to work with the SEA, and LEAs, to clarify the issues of referral and screening.

Meetings have been held throughout FY '81 between staff of the Preventive Medicine Administration, DHMH, and the Division of Special Education, MSDE. Staff from DHMH have participated in meetings and inservice training for Child Find coordinators. A draft referral process for the state neo-natal program has been developed as part of what will become a comprehensive approach to how health personnel can refer young handicapped children to local school systems.

This proposed referral system will be refined during FY '82 and included in the statewide plan. This referral system will provide guidelines for health personnel to readily access special education and related services for young handicapped children and their families. The system will also aid LEA special education personnel in referring young handicapped children and their families for health services.

1. Maryland State School Health Council:

During 1980 the Maryland State School Health Council joined in a collaborative effort with the Division of Special Education to sponsor a conference which included physicians, nurses, supervisors of local special education departments and local health officers. The purpose of the conference was to address a variety of issues related to delivery of services to young handicapped children. The first step in developing a collaborative approach between health and education was to identify the target audience for each program and to identify the referral process.

This effort resulted in a number of subsequent activities which were targeted to Child Find activities within health agencies.

2. American Academy of Pediatrics Project:

The Division of Special Education in cooperation with the American Academy of Pediatrics conducted the Physicians Training Project which served to orient physicians relative to the education of children with school related handicaps. Training was provided for twenty physicians on October 7-9, 1981.

One of the primary training objectives for the training was to familiarize physicians with the referral process, criteria for placement of a handicapped child into special education, the physician's role in screening, identification, assessment, and available educational services for handicapped children in Maryland. Two members of the SIG Consultant Panel participated in this joint medical/special education training project.

3. Developmental Disabilities Council:

The Division of Special Education participated in and supported the activities of the Developmental Disabilities Council. The Council consists of many agencies and consumer groups that are involved in the Maryland service delivery system for handicapped children. Several members of the Division attended both full Council meetings and participated in task force meetings regularly. The Council is represented on the SIG Consultant Panel. During FY'81, the Division supported the efforts of the Developmental Disabilities Council to develop a process of voluntary registration of specific birth conditions in order to provide information and support to parents in accessing available services. This registration may significantly aid efforts to provide early and appropriate services to handicapped children, beginning at birth.

4. Agreements:

During FY'81, the Division worked toward developing a cooperative agreement between the Maryland State Department of Education, Division of Special Education, and the Maryland State Department of Health and Mental Hygiene, Crippled Children's Services, S.S.I Disabled Children's Program (DCP). The emphasis is on the coordination of individualized education programs (IEP) and individual service plans for referrals of handicapped children under 7 years of age.

The Department of Education (through local school systems) and the SSI/DCP will refer those handicapped children to the appropriate agency/resource for supportive services. All referrals from an educational agency will be for handicapped children age birth to sixteen years of age who are receiving SSI benefits. Referrals will be made to the appropriate case manager of the SSI/DCP according to the child's geographical location (home) with feedback to the school system indicating additional services and case status. Referrals to an educational agency for special education services will be coordinated through the local Child Find Coordinator or administrator for special education with feedback from the local Child Find Coordinator to the SSI/DCP case manager indicting follow up services, school placement, etc. Referrals of handicapped will be accepted for those children birth through 20 years of age. Appendix D contains a copy of the agreement.

The Division also provided technical assistance to the Prince George's Boards of Health and Education in the development of an agreement which addresses the provision of school health services and referral procedures for children receiving services through both systems. Both of these agreements may serve as a model for the development of similar procedures between health and education agencies at the local level.

5. Hospital/Clinic Liaison:

The Division of Special Education maintained a liaison with two area hospitals which provide genetic counseling and support for parents and handicapped children. Specifically, a liaison was initiated during 1980 with the Johns Hopkins University Pediatric Genetics Clinic, Baltimore, Maryland, for the purposes of:

- training seven early childhood-special education teachers in Baltimore City, Baltimore County, and Anne Arundel County,
- maintaining a referral system for support services and training for parents, maintaining a referral system to local special education programs.

In addition, cooperation with the Johns Hopkins Hospital Clinic has been expanded for the purpose of creating a climate conducive to cooperative efforts between the fields of health and education. One goal of this liaison will result in a holistic approach to aiding families of children with a genetic disorder. By developing a coordinated referral plan for comprehensive services between education and health it is expected that this goal will become a reality.

Staff of the Pediatric Genetics Clinic, Johns Hopkins University, have participated in two state initiated inservice training programs conducted in September, 1980 and March, 1981. Approximately 80 administrators participated in the session conducted by staff of the Genetic Clinic.

In addition to the liaison with the Johns Hopkins Hospital program, collaborative activities have also been conducted with the Genetic Counseling Service of Sinai Hospital, Baltimore, Maryland. This liaison has resulted in a referral system, as well as inservice training for Maryland teachers and related service providers.

Specifically, project staff have participated in a conference entitled "Downs Syndrome for Parents and Professionals" conducted on November 16, 1980.

6. EPSDT Program:

During FY'81, the Division was involved in a variety of initiatives to explore ways in which school systems could be integrated into and benefit from the implementation of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program. A member of the SIG Consultant Panel is represented on the Governor's Task Force on EPSDT. Many of the diagnostic services provided to the Medicaid eligible child through the EPSDT Program can result in the identification of young children suspected of having a handicapping condition.

During FY '82, the SIG Consultant Panel will review the accomplishments of the preceding activities with consideration of both the process and outcome of each activity. Thus, these activities, although specific to the areas of Child Find, joint service delivery and referral, may serve as models of interagency collaboration for other identified areas, such as personnel preparation and parent involvement in early intervention.

III. SUMMARY OF RESULTS

The following lists the three objectives of the FY'80 project and a summary of the results.

Objective 1.0 - Create an interdisciplinary consulting group to examine issues related to delivery of services for handicapped children from birth to age three.

A Consulant Panel was identified and administrative support was gained from respective agencies. The Consultant Panel provided input for the development of a matrix of services (Appendix A) and recommendations for the statewide plan. The panel was instrumental in the review and revision of draft plans.

Objectives 2.0 - Conduct awareness activities with the LEAs and related agencies in support of approved procedures.

This project resulted in:

(1) a draft state plan regarding educational services for handicapped children from birth to age 3, and

(2) recommended tasks for achieving the goals and objectives of the draft state plan.

Many of the strategies outlined in the plan are directly applicable to improving service delivery system for handicapped children from age three through five.

Further, the maintenance of a working interagency consultant panel improved the communication network among agencies concerned with services to young handicapped children and their families.

The plan and procedures resulting from this project were tailored to the specific needs of Maryland's state and local education agencies. However, numerous other states serving young handicapped have requested copies of Maryland's draft plan.

The following activities were conducted to increase understanding of this project.

- an early childhood committee, composed of LEA representatives, was formed to disseminate information regarding the SIG Project.

  Numerous presentations were made at national, state and local conferences and meetings,
- SIG staff conducted a needs assessment within Maryland's 24 LEAs relative to planning for handicapped children from birth to age three.
- SIG staff provided technical assistance and developed information packages relative to planning for young handicapped children.

APPENDIX A

MATRIX OF SERVICES

AGENCY SERVICES

Agency/Programs	SERVICE AREAS																				
	Alternative Community Living Arrangements					Child Development						Case Management		Nonvocational - Social Development							
	Residential Services			School Age		Pre-School		Identification						Treatment			Support				
Federal and State	Respite Care	Special Living Arrangements	Foster Care	Day Care	Educational Training	Day Care - Infant Stim.	Education/Training	Diagnosis Eval.	Early Intervention	Information Referral	Counseling	Protective, Social, Legal	Monitoring	Institutional Care	Dental Medical	OT/PT/SPH, Other Therapies	Recreation	Personal Care	Transportation	Parent/Home Intervention	Personal Prep.
*Education:																					
Special Education					X	X	X	X	X	X	X	X	X			X	X		X	X	
Vocational Tech. Educ.					X																
Vocational Rehab.								X			X								X		
CUSP: ECE-EEEP							X	X	X												
Title I					X		X	X	X	X	X		X	X	X			X	X	X	
ESEA Title IV-C							X	X	X	X	X									X	
Migrants						X	X	X	X	X	X		X		X				X	X	
Pupil Services			X		X		X	X		X	X	X	X							X	
*Human Resources:																					
Social Services		X	X							X	X	X		X	X		X	X	X		
*Preventive Medicine:																					
SSI for Children						X						X									
Div. of Infant, Child & Adoles.				X				X										X			
Crippled Child. Serv.								X					X		X	X			X		
Div. of Hereditary Disorders								X					X								

	Respite Care	Special Living Arrangements	Foster Care	Day Care	Educational Training	Day Care - Infant Stim.	Education/Training	Diagnosis Eval.	Early Intervention	Information Referral	Counseling	Protective, Social, Legal	Monitoring	Institutional Care	Dental Medical	OT/PT/SPH, Other Therapies	Recreation	Personal Care	Transportation	Parent/Home Intervention	Personnel Prep.
Mental Health																					
Headstart										X	X			X	X						
Mental Retardation	X	X			X			X	X	X		X		X	X	X	X	X	X		
J. F. Kennedy Inst.	X							X	X	X	X		X		X						
Walter Carter Center								X	X			X									
Medical Assistance															X						
Develop. Disab. Counc.										X											

AGENCY SERVICES

Agency/Programs	SERVICE AREAS																				
	Alternative Community Living Arrangements						Child Development					Case Management			Nonvocational - Social Development						
	Residential Services			School Age			Pre-School		Identification						Treatment			Support			
	Respite Care	Special Living Arrangements	Foster Care	Day Care	Educational Training	Day Care - Infant Stim.	Education/Training	Diagnosis Eval.	Early Intervention	Information Referral	Counseling	Protective, Social, Legal	Monitoring	Institutional Care	Dental Medical	OT/PT/SPH, Other Therapies	Recreation	Personal Care	Transportation	Parent/Home Intervention	Personnel Prep.
Private/Other																					
Local Assoc. for Retarded Citizens	X	X					X		X			X						X		X	
United Cer. Palsy Assoc.	X	X			X		X					X				X	X	X	X		
Epilepsy Assoc. of Md.										X	X	X									
Md. Society for Autistic Children		X								X		X									
Owarll Program	X																	X			
Centers for Handicapped					X	X	X	X	X	X	X				X	X		X	X	X	X
University of Maryland																					
Local ACLD					X					X		X									
Hearing & Speech Agency					X			X													
League for Handicapped																	X				

APPENDIX B

STATE PLAN

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STATE PLAN

State Implementation Grant
Maryland State Department of Education
Draft Plan for Services for Handicapped Children
Birth to Three Years

The purpose of the plan is to support and structure the commitment of MSDE to the provision of comprehensive services for all handicapped children birth to age three. Pursuant to this purpose, the SIG consultant panel has generated recommendations addressing issues concerning: Development of Public and Professional Awareness of Child Find Activities, Screening and Assessment. The following is submitted as a working paper for discussion and review by SIG panel participants, NASDSE consultants, LEA Input Team and MSDE personnel. The plan details goals and recommended activities at the State level, with implications for expansion to local level activities.

Many of the action steps cited in the draft are presently underway as Maryland completes its first year of mandated state wide services for handicapped children.

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CONSULTANT PANEL FOR
STATE IMPLEMENTATION GRANT

Ms. Carol Ann Baglin
Maryland State Department
of Education

Ms. Kate Kressley
Maryland State Department
of Education

Ms. Lin Leslie
Maryland State Department
of Education

Mrs. Frances Witt
Maryland State Department
of Education

Dr. Paula Bell
University of Maryland

Mr. Edward Feinberg
Anne Arundel County Public Schools

Susan Cassidy-Bronson
Cecil County Public Schools

Ms. Diane Petersen
Maryland State Teacher's Association

Mrs. Marian Monk
Department of Human Resources

Dr. Polly Roberts
Department of Health and
Mental Hygiene

Mrs. Catherine Raggio
Maryland State Planning Council
on Developmental Disabilities

Mrs. Barbara Strickler
Centers for the Handicapped

Parent Participants

Jay and Susan Oakley
7727 B. Nelson Loop
Fort Meade, Maryland 20755

Stephan and Susan Louis
2928 Chestnut Road
Edgewater, Maryland 21037

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Goal Statement

I. Public and professional awareness of Child Find activities and special education services for handicapped children birth to three years will be developed.

II. Child Find activities will be implemented.

III. All children birth to three years who are suspected of having a handicapping condition will be screened.

IV. All children birth to three years who are referred for assessment or positively screened for a potential handicapping condition will be assessed.

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Definitions and Purpose

The following definitions and purposes are specific to handicapped children, aged birth to three, and services to that population in the State of Maryland, and are not intended to be broad or general.

Child Find Public and Professional Awareness

Definition: Public and professional awareness is the ongoing process of informing the community concerning the availability and value of special education services for exceptional children birth to three years.

Purpose: The purpose of public and professional awareness is to inform and educate community members concerning the right to a free and appropriate education for all handicapped children and to generate referrals to Child Find.

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Child Find Activities

Definition: Child Find is the ongoing process of locating children suspected of being handicapped and referring these children for appropriate evaluation services.

Purpose: The purpose of the Child Find process is to seek out and locate children suspected of having a handicapping condition who may be in need of special education and related services evaluation.

Screening

Definition: Screening is the ongoing process of identifying children, from the general population, who present a reasonable likelihood of having special educational needs.

Purpose: The purpose of screening activities is to gain information about children referred through Child Find activities to determine the need for a thorough assessment.

Assessment

Definition: Assessment is defined as the systematic process of multidisciplinary evaluation which measures a child's performance against established standards. This process results in a description of the child's unique behavioral patterns and style of performance and his or her level of functioning, including strengths and weaknesses, in sensory, developmental and social/emotional areas.

Purpose: The purpose of assessment is to collect the information to determine the presence and nature of handicapping conditions, and to support recommendations for the design and implementation of appropriate intervention or programming, including level of service, provision of related services, instructional objectives and teaching strategies.

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I. Child Find Public and Professional Awareness Development

1.0 Goal Statement: Public and professional awareness of Child Find activities and special education services for handicapped children birth to three years will be developed.

1.1 Objective: To develop and implement a system (model) to build public and professional awareness.

Action Steps:

1.1.1 Identification of SEA personnel as coordinator(s) of the system.

1.1.2 Identification of all agencies to be made aware of Child Find and special education services. The agencies to be contacted directly by the most appropriate means will include, but not be limited to:

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- o Local educational agencies
- o State and County Public Health Agencies
- o State and Local Social Services Agencies
- o Private schools and day care centers
- o Regional and local Head Start Programs
- o Institutes of Higher Education
- o State and Local Public Service Agencies
- o State and Local Public Information Outlets
- o Department of Mental Health
- o Private Physicians
- o EPSDT Providers
- o Hospitals serving infants
- o Hot Lines

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1.2 Objective: To prepare personnel to conduct public and professional awareness activities.

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Action Steps:

1.2.1 Development of a trainer of trainers model specifying training content:

- goals and objectives of training
- format of training (formal and informal)
- duration and frequency of training

Content will include, but not be limited to the following:

- How to develop a local network of agencies (involved with population of birth to three year olds) for purposes of information sharing.
- How to identify target audiences.
- How to use formal and informal information channels.
- The nature of normal child development.
- The nature of exceptional developmental patterns.
- Early signs of exceptional developmental patterns.
- The need for early intervention.
- The scope of special educational and related services available.
- How to contact persons regarding services.
- Information on the right to a free appropriate education for the handicapped.
- How to evaluate awareness activities at the local level.

1.2.2 Implementation of New Directions for the Handicapped - Physicians Training Project.

1.2.3 Implement staff development model.

1.3 Objective: To develop cooperative liaisons with state agencies involved with populations of young children (See Appendix B).

Action Steps:

1.3.1 Identify types of personnel in agencies, who will be appropriate for liaison activities.

1.3.2 Recommend support from MSDE specialists (graphic arts, public information) to assist in campaign implementation.

1.4 Objective: To develop a system (model) for using support services in an effective public and professional awareness campaign.

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Action Steps:

1.4.1 Identify public information resources at state and local levels.

1.4.2 Identify and/or produce print and media materials for dissemination, with interagency input and participation.

1.4.3 Share of produced documents within and among agencies (See Appendix B).

1.4.4 Evaluate and revise materials if necessary.

1.5 Objective: To evaluate the effectiveness of the public and professional awareness campaign.

Action Steps:

1.5.1 Determine criteria for evaluation.

1.5.2 Compile data

1.5.3 Revise procedures as necessary.

II. Child Find Activities

2.0 Goal Statement: All potentially handicapped children aged birth to three will be located and referred for screening or assessment.

2.1 Objective: To develop an interagency system (model) to locate children birth to three years for the purpose of identifying those who may be handicapped and in need of special education (See Appendix B).

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Action Steps:

2.1.1 Pursue interagency cooperation regarding:

- o Common or specific criteria relative to the identification of handicapped children from general population as in high risk birth record data.
- o The use of agency resources to locate children suspected of being handicapped.
- o The use of compatible processes, forms and activities.

2.1.2 Develop interagency liaison(s) network - for Child Find activities.

2.1.3 Develop procedure to transmit Child Find data among agencies.

Maintain SEA Child Find Hotline.

- o Maintain SEA referral process to other state agencies and LEAs.
- o Maintain log of referrals/inquiries.
- o Maintain follow-up process to ensure appropriate evaluation (screening and/or assessment) sevices.

2.2 Objective: To appropriately prepare Child Find personnel.

Action Steps:

2.2.1 Identify target audience. Target audience may include, but not be limited to, liaisons from the following agencies:

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- Educational Agencies
    - LEAs
    - Head Start
    - Institutes for Higher Education
- Department of Health and Mental Hygiene
    - State and Local Health Departments
    - Maternal and Child Health
    - Crippled Children's Services, including Supplemental Security Income/Disabled Children and Youth.
    - EPSDT
    - Nursing Services, i.e., Public Health, School Services
- Department of Human Resources
    - Social Services
    - Foster Care
    - Protective Services
    - Day Care
    - Services to Families with Children
- Social Security Administration
    - Supplemental Security Income for Disabled Children and Youth
    - Medicaid

- Medical Centers

  The Johns Hopkins University

  The Kennedy Institute

  Sinai Hospital

  University of Maryland

  Children's Hospital National Medical Center

  The National Children's Hospital Center (D.C.)

  Georgetown University Medical Center

  Bethesda Naval Hospital

  Walter Reed Army Hospital

  Dupont Medical Center

  Other hospitals providing intensive care to neonates

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- Private Educational and Human Services Programs Serving Preschool Handicapped.
- Advocacy Groups

  Developmental Disabilities Council

  Prince George's County Coalition

  Association for Retarded Citizens

  Associations for Children with Learning Disabilities

  Maryland Advocacy Unit for the Developmentally Disabled

2.2.2 Develop trainer of trainers model specifying:

- goals and objectives of training.
- format of training (formal and informal).
- duration and frequency of training activities.

2.2.3 Develop training content which will include, but not be limited to, the following (See also Appendix C):

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- Content material listed under public and professional awareness training.
- How to implement public and professional awareness activities.
- How to use state and local matrix of services.
- How to use public information resources at local level.
- How to use associations and civic groups at the local level.
- How to refer to community resources for ancillary services and assistance, i.e., Respite Care, SSI.
- How to transmit referrals from Child Find to appropriate screening/assessment personnel.
- How to keep records and collect data.
- How to evaluate Child Find activities at the local level.

2.2.4 Implement staff development model.

2.3 Objective: To evaluate the effectiveness of Child Find Activities.

Action Steps:

2.3.1 Determine criteria for evaluation

2.3.2 Compile data

2.3.3 Revise procedures as necessary.

III. Screening

Goal Statement: All children birth to three years who are suspected of having a handicapping condition will be screened.

3.1 **Objective**: To develop a system (model) to provide screening of children within the birth to three population who are suspected of having handicapping conditions.

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Action Steps:

3.1.1 Recommend personnel to act as coordinator(s) of state level activities related to interagency screening functions.

3.1.2 Pursue interagency agreements to develop, secure and/or maintain (See Appendix B):

- Provision of screening processes to detect abnormalities in health, vision, hearing, language, cognitive motor, and social/emotional functions.
- Procedures for access to pertinent screening data results with appropriate parental permission and confidentiality safeguards.
- Provision for coordination between LEAs and local health departments for tracking high risk children (See Appendix G).

3.1.3 Recommend guidelines to assist LEAs in coordinating, securing or providing screening services for the birth to three population (See Appendix D). The guidelines shall address:

- Strategies and procedures for coordinating screening activities with local departments of public health, primary care providers (physicians, nurse practitioners) and EPSDT programs (See Appendix B).

- Benefits and purposes of screening services.
- Identification of formal and informal screening instruments appropriate for the birth to three year old population (See Appendix F).
- Compilation of various screening program models.
- Conditions/circumstances which warrant waiver of the screening step in identification process.
- Record keeping and data collection.
- Referral process of "positive" screening results for indepth assessment.
- Tracking process of "questionable" screening results.
- Utilization of community resources for access to nonspecial education services.
- Parents' rights and involvement in screening process.
- Evaluation of local screening activities to determine cost and identification effectiveness.

3.2 Objective: To conduct screening with appropriately trained personnel.

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Action Steps:

3.2.1 Develop a trainer of trainers model specifying:

a. Identification of target audience to be trained.

- LEA Child Find Coordinator
- LEA Early Childhood Special Education Supervisors/Program Specialist
- Health Department Public Health Nurse(s), Physician Assistants, Nurse Practioners, Supervisors
- Hospital Obstetrical and Pediatric Staff

- Vision and Hearing Personnel
- Health Department EPDST Supervisors
- LEA Speech Pathologist Supervisors
- LEA Psychologist Supervisors
- LEA School Nurse Supervisors
- LEA Supervisors of OTs and PTs
- Health Profession Association Representative
- Representatives of IHEs
- Other appropriate personnel

b. Long term and short term objectives for training.

c. Specification of format of training - formal and informal.

d. Content of training.

3.2.2 Staff development activities will be implemented.

3.3 Objective: To utilize appropriate screening materials.

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Action Steps:

3.3.1 Disseminate guidelines and procedures manual (3.1.3) to address administration and direct services needs germane to screening functions.

3.3.2 Compile sample instruments and devices to be made available for review of LEAs and cooperating agencies (See Appendix F).

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3.4 Objective: To evaluate the effectiveness of screening activities.

Action Steps:

3.4.1 Determine criteria for evaluation.

3.4.2 Compile data.

3.4.3 Revise procedures as necessary.

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IV. ASSESSMENT

4.0 Goal Statement: All children birth to three years who are referred for assessment or positively screened for a potential handicapping condition will be assessed.

4.1 Objective: To develop a system (model) to provide for assessment of children birth to three years who are suspected of having a handicapping condition and being in need of special education.

Action Steps:

4.1.1 Pursue interagency agreements to develop, secure and/or maintain (See Appendix B):

- Provision of assessment/diagnostic procedures to detect handicapping conditions related to abnormalities in health, vision, hearing, language, cognitive, motor, and social/emotional functions.
- Procedures for securing pertinent assessment data results with appropriate parental permission and confidentiality safeguards.
- Procedures to avoid duplication of testing among agencies.

- o Procedures to ensure timely receipt of assessment data to local ARD committees.
- o Provision for coordination between LEAs and health departments for tracking high risk children (See Appendix G).

4.1.2 Recommend guidelines to assist LEAs in coordinating, securing or providing assessment services for the birth to three population (See Appendix E). The guidelines shall address:

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- o Strategies and procedures for coordinating LEA assessment activities with local departments of public health, primary care providers (physicians, medical specialist), medical center diagnostic teams, EPSDT programs (See Appendix B).
- o Qualified examiner requirements, within Maryland Bylaw and certification specifications, for the birth to three year old population.
- o Procedures for multidisciplinary involvement in certification of handicapping condition.
- o Process for transmittal of assessment data to ARD committee at LEA level.
- o Procedures for multidisciplinary staffing to provide programmatic recommendations for services and IEP development.
- o Procedures to ensure confidentiality of data.
- o Procedures to safeguard parents rights and to involve parents in assessment process and in development of the IEP.
- o Process to maintain census of children requiring special education services (SSIS).

4.1.3 Recommend guidelines to assist LEAs in implementing the assessment process, including (See Appendix E):

- Criteria to assist local ARD committees in differentiating handicapped infants from at risk infants (See Appendix G).
- Suggested school and other agency personnel to comprise core assessment team:
    - Early Childhood Special Educator
    - Speech Pathologist
    - Psychologist
    - Occupational/Physical Therapist
    - Other (e.g. Early Childhood Educator, Physician, Social Worker, etc).
- Instruments appropriate for "educational" assessment of birth to three year olds (See Appendix F).
- Suggestions for interpreting assessment findings for educationally adverse effects.
- Techniques for gathering assessment information.
- Suggestions for format of comprehensive written report.
- Suggestions for interpreting assessment findings and recommendation to parents.

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4.2 Objective: To develop personnel development activities relative to assessment of the birth to three population.

Action Steps:

4.2.1 Identification of SEA coordinator of inservice training specific to assessment of the birth to three population.

4.2.2 Identification of target audience to be trained. Personnel may include but not be limited to:

- o LEA Early Childhood Special Education Teachers
- o LEA Speech/Language Pathologists
- o LEA Psychologists
- o OTs and PTs
- o Other agency professionals involved in assessment activities (e.g. Early Childhood Educators, Social Workers, etc.).
- o Private physicians/therapists

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4.2.3 Identification of multidisciplinary consultants for assessment of the birth to three population.

4.2.4 Utilization of consultants in determining training content and appropriate training format. Content may include but not be limited to:

- Selection and administration of normative and criterion referenced instruments appropriate to the birth to three population.
- Formal and informal evaluation techniques.
- Case history data collection and interpretation.
- Inclusion of parent in assessment process.
- How to participate on a multidisciplinary team.
- Formulating comprehensive written/oral reports.
- Preparation for role of case manager for individual children.

4.2.5 Utilization of appropriate personnel (consultants, MSDE and cooperating agency professionals - See Appendix B) in implementing state and local level training.

4.2.6 Utilization of state evaluation system to determine effectiveness of training at local level.

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4.3 Objective: To identify technical assistance resources to assist LEAs and cooperating agencies in providing assessment to the birth to three population.

Action Steps:

4.3.1 Early Childhood Special Education, MSDE specialists will be available to provide regional and/or county based training to personnel involved in assessment activities.

4.3.2 A collection of formal and informal assessment devices will be compiled for use in training sessions and for review by LEAs (See Appendix F).

4.3.3 Guidelines suggesting appropriate uses of instruments will be distributed.

4.3.4 National, regional and local technical assistance resources will be identified, i.e.,

- Experienced Local Service Providers
- Technical Assistance Development System (TADS)
- Mid Atlantic Regional Resource Center (MARRC)
- National Association of State Directors of Special Education (NASDE)
- Institutions of Higher Education (IHE)
- Council for Exceptional Children (CEC)

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4.4 Objective: To evaluate the effectiveness of the assessment process.

Action Steps:

4.4.1 Develop criteria for evaluation.

4.4.2 Compile data

4.4.3 Revise procedures as necessary.

APPENDIX B

INTERAGENCY AGREEMENTS

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Interagency agreements are specifically called for in sections 3.1.2 and 4.1.1 of the Plan. However, in various other sections, such as 1.4.3, 1.3, 2.1, 3.1.3, 4.1.2, and 4.2.5, references are made to developing interagency coordination for purposes of personnel training, sharing of documents, location, screening, and assessment. Indeed, intragency cooperation would be beneficial as a whole in locating and serving the birth to three handicapped population.

Outcomes

Duplication of services is certainly a waste of resources; however, it may be avoided by joint planning with social, health, and rehabilitation agencies for service delivery. The obvious outcome of interagency cooperation is better service delivery to all clients. More specifically, four advantages can be pinpointed:

- Individualized service planning - instead of a number of separate individual service plans being written by several different agencies, one common plan may be jointly developed for each client.
- Organization and delivery of services - a single effort reduces the waste of service duplication or overlap.
- Program monitoring and reporting - interagency cooperation may provide for common accessible information, rather than

duplication of records and files, as well as cooperative report writing to save personnel resources.

- Program planning and budgeting - shared resources can maximize dollars. Additionally, a united front is created for seeking funding.

In order to assure that interagency coordination is effectively carried out, written agreements are necessary. Following is a description of types of agreements, and some guidelines for preparing, developing, and following through on written interagency agreements.

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Types of Agreements

Three major classes of interagency agreements may be identified:

1. In the first type, common or baseline standards are established for the conduct of programs which are similar. An example of this may be an agreement between state or local education agencies and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, for the purpose of establishing common and specific criteria for identifying infants and preschoolers who are suspected of having a handicapping condition and are in need of further assessment.
2. The second type are commitments regarding the allocation of public school and other agency resources in the accomplishment of mutually agreed upon objectives. This usually involves sharing dollars, personnel, facilities, and/or equipment. An agreement between an LEA and a local hospital, providing that the hospital will serve as the location for preschool screening, is an example of this type.

3. The third type involves a commitment by public schools and other agencies offering comparable services to maintain uniform procedures, forms, and activities. For example, in this type of agreement, Child Find personnel and public health nurses may use the same standard form when screening infants for potential handicaps.

Agreements regarding standards (Type 1) and allocation of resources (Type 2) are necessary before agreements regarding procedures and activities (Type 3) can be implemented, although the three types are not mutually exclusive and may all be contained in the same agreement.

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Process

Preparation - For an interagency agreement to be effective, an initial commitment by persons in key roles in both agencies is necessary. These persons must be willing to cooperatively define their agency's role in relation to the agreement and quality service delivery. The first step in preparing for an agreement is for the initiating agency to document service needs and subsequently identify other key agencies and resources with which collaboration may be necessary or helpful. At this point, it is helpful for the initiating agency to become familiar with the other agency by reviewing the pertinent laws and regulations that apply, and by getting to know the internal workings of the agency as much as possible.

It will be necessary to identify a person or group from each agency whose specific responsibility it is to coordinate the development and implementation of the agreement. This person should have enough authority so that their activities and decisions are legitimate and should be able to make a significant time commitment to

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the collaboration activities. In addition, the specific roles and responsibilities of this person in each agency should be designated, so that if a person should leave an agency, interagency collaboration can continue with a new person in the same position.

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Development of Agreement - It is a good idea to start small with a plan in mind. The agencies involved should cooperatively identify problems and specify solutions for service delivery. The resources to be exchanged can then be identified, and the trade-off should be as equal as possible. It is also important to identify the resulting benefits to each agency in addition to the resources to be used. In developing the agreement, the agencies should specify under what conditions and to what extent the resources will be exchanged. A draft of the agreement should then be developed, to proceed through the proper channels of approval in each agency, and the final decision should be by consensus of both agencies.

Implementation - The benefits identified should provide the incentive for each agency to carry out the agreement. The agreement policy should have been appropriately designed so as to not conflict with the policy of either individual agency and to assure that the changes in the programs are implemented. It is important to monitor the effect of the agreement on services to be sure that the outcomes are beneficial to the clients and both agencies. The most critical element in effectively implementing an interagency agreement is communication. All persons involved in collaboration activities in each agency should be fully informed about the agreement and its implication; there should be no secrets or surprises for anyone.

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Characteristics of a Good Agreement

The written agreement should be composed of simple, clear language, stating what has been agreed to and who will implement which parts. The process for implementation should be flexible; outcomes rather than process should be emphasized. The individual and mutual benefits for the agencies involved should be included in the written agreement. The essential components of any written interagency agreement are as follows:

a. Description of purpose to be achieved through agreement.

b. Clear delineation of specific program, service, or focus for the agreement to facilitate clear communication of the need for and intent of the agreement.

c. Definition of any terms that could be ambiguous.

d. Mutually agreed upon goals and/or objectives of the agreement.

e. Delineation of specific roles and responsibilities of each party to the agreement.

f. Mutual/shared responsibilities of all parties to the agreement.

g. Designation of the agency which has first dollar responsibility for payment of services and specification of other financial or funding arrangement for payment of services.

h. Specific actions to be taken relative to the program/service identified in agreement (Action Plan).

i. Specific services to be provided by each party.

j. Designation of staff position(s) within each agency responsible for:

  - implementing the agreement as specified,
  - monitoring the implementation,

- negotiating change when necessary to update agreement.

k. Confidentiality assurances relative to sharing of information.

l. Agreement among parties for notification in cases of changes in agency operations.

m. Specification of time period for agreement to remain effective.

n. Procedure for modifying or terminating written agreement.

o. Evaluation design specified and agreed upon by all parties to be used in monitoring implementation of agreement; identification of person(s) rsponsible for evaluating and sanctions agreed upon to assure its implementation.

p. Signatures of all parties involved in agreement.

All of the above components may not be applicable to every type of agreement. Additionally, the following optional components may be helpful or desirable in some agreements:

a. Description of basis for developing the written agreement
  - Previous/on-going relationship between parties, identification of common need, institutions of new service, etc. as foundation for current agreement.
  - Legal authority based on federal and state legislation.

b. Definitions for agency or program-specific terms used in the agreement.

c. Eligibility criteria/description for population to be serviced or affected by agreement.

d. Specification of meetings (time, dates, frequency) relative to terms of the agreement.

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e. Specification of reporting mechanisms between parties of the agreement.

f. Schedule for periodic review of agreement.

g. Additional assurances (e.g. referral mechanisms, mechanisms for updating, revising, etc.)

h. Specification of additional incentives to be provided as a result of the written agreement, i.e., funding additional staff, work space, etc.

Other Agencies

In providing services to the birth to three handicapped population, collaboration with a variety of agencies may be desirable. The following is a list of federally funded programs, other than special education, which provide services of some type to this population:

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Maternal and Child Health Services
Crippled Children's Services
Developmental Disabilities Services
Supplemental Security Income - Disabled Children's Program
Head Start Programs
Social Services

Some interagency agreement already exists between these agencies at the federal level. LEAs are also encouraged to develop interagency agreements with state and locally funded as well as private programs if the result is better service delivery to handicapped children age birth to three.

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References and Further Information:

A Guide for Developing Interagency Agreements. Available from: Printing Section, Department of Education, P.O. Box 44064, Baton Rouge, Louisiana, 70804.

Kazuk, E., Greene, L. & Magrab, P.R. Case study for planning coordinated services. In Magrab, P.R. and Elder, J.O. (Eds) Planning for Services to Handicapped Persons: Community Education Health. Baltimore: Brooks Publishers, 1979.

Audette, R.H. The Public School Administrator's Guide to Interagency Cooperation: Implementing the Education for All Handicapped Children Act. (Available from MSDE)

The Regional Resource Center Task Force on Interagency Collaboration. Interagency Collaboration on Full Services for Handicapped Children and Youth: A guide to State Level Plannng and Development (5 Volumes). DHEW/BEH, 1979. (Available for loan from MSDE).

Example

Following are several interagency agreements provided as examples. LEAs are encouraged to examine Appendix B carefully before attempting to formulate agreements, rather than simply modeling agreements after the examples.

DRAFT of

Cooperative Agreement

Between

Maternal and Child Health Services,

South Dakota Department of Health

and

The Section for Special Education,

South Dakota Department of Education and Cultural Affairs

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Purpose:

The purpose of the cooperative agreement is to coordinate the efforts of both agencies toward the success of area-wide screenings. Efforts will be coordinated in order to cut down on duplication of services and in order to utilize already existing services to identify, evaluate, and appropriately place children in need of special and prolonged assistance.

The purpose of these screenings include: 1) identification of children with complex, chronic problems who thereby would be eligible for Crippled Children's Services, 2) referral of any identified problem to the proper source of care, 3) to aid in development of a proper treatment plan or individual educational plan, and 4) to identify various agency funding sources for the identification, evaluation, and placement of these children.

Responsibilities of Maternal and Child Health Services, South Dakota Department of Health:

MCHS agrees to:

1. Conduct area-wide screenings in the West and Missouri Valley Regions.
2. Provide follow-up to all identified medical problems.
3. Provide information to appropriate agencies concerning possible funding sources for further evaluations.
4. Send educational referrals to the appropriate local school district.
5. Send educational referrals to the Section for Special Education, South Dakota Department of Education and Cultural Affairs, for appropriate follow-up.
6. Review this agreement on an annual basis.
7. Designate Timothy Schmaltz, Director of Health Services Division, for liaison activities between departments and cooperation with the area-wide screening teams.

Responsibilities of the Section for Special Education, South Dakota Department of Education and Cultural Affairs:

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The Section for Special Education agrees to:

1. Inform local school districts of the importance in using the services provided by Maternal and Child Health Services for their Child Identification efforts.
2. Encourage local school districts to follow correct procedures for all referrals made as a result of the screenings.
3. Provide follow-up for educational referrals made to the Section for Special Education.
4. Review this agreement on an annual basis.
5. Designate Norena Hale, Special Education Administrator, for liaison activities between departments and cooperation with the area-wide screening teams.

Assurances:

1. This agreement may be amended by mutual consent of both parties and may be terminated by either party upon thirty (30) days' written notice to the other party.
2. This agreement becomes effective on the date and year that both parties have signed this agreement.

Maternal and Child Health Services
South Dakota Department of Health

______________________________ ______________________________
Secretary Date

The Section for Special Education
South Dakota Department of Education and Cultural Affairs

______________________________ ______________________________
Secretary Date

INTERAGENCY COOPERATIVE SERVICES AGREEMENT

Department of Mental Health and Mental Retardation

and

Department of Education

DRAFT

This interagency cooperative services agreement was made and entered into March 1, 1978, by and between W. E. Campbell, Ed. D., Superintendent of Public Instruction, Virginia Department of Education and Leo E. Kirven, Jr., M. D., Commissioner, Virginia Department of Mental Health and Mental Retardation and amended April 1, 1979.

The purpose of this amended agreement is to provide maximum coordination and utilization of services of each Department in order to be consistent with the Revised State Plan for the Identification and Diagnosis of Children Who Are Handicapped, which was transmitted to Governor Godwin on January 11, 1978.

The provisions of this agreement, as amended April 1, 1979, shall reflect the policies of the Department of Mental Health and Mental Retardation and the Department of Education, and shall become effective upon the date signed by the Superintendent of Public Instruction and the Commissioner of the Department of Mental Health and Mental Retardation. The agreement shall terminate upon the written request of the Commissioner or Superintendent. This agreement may be amended by mutual consent of the parties concerned, and it will be amended if required by Federal or State laws or regulations.

The Department of Mental Health and Mental Retardation agrees to the following:

1. To encourage Community Mental Health and Mental Retardation Services Boards to cooperate in child find procedures required by local school divisions.
2. To encourage Community Mental Health and Mental Retardation Services Boards to enter into contractual agreements with local school divisions and Health Departments for the provisions of diagnostic evaluation and treatment services for emotionally disturbed children.
3. To encourage Community Mental Health and Mental Retardation Services Boards to develop treatment programs for emotionally disturbed and mentally retarded children in cooperation with educational programs for such children provided by local school divisions.
4. To provide special education programs for mentally retarded children ages 2 to 21 residing in State mental retardation facilities in order to receive treatment and habilitation training, in accordance with Board of Education regulations.

   Education programs will be provided at no cost to the parents. The treatment and habilitation training will be subject to DMHMR reimbursement in compliance with Section 37.1-105 through 37.1-119 of Code of Virginia.

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5. To encourage the coordination of educational programs with treatment programs provided for handicapped children in State mental health and mental retardation facilities.

6. To provide adequate space for the special education program within State mental health and mental retardation facilities.

7. To provide access to information needed for the supervision of educational programs by authorized representatives of the Department of Education in those State facilities operated by the Department of Mental Health and Mental Retardation.

8. To cooperate with the Department of Education in a study of mental health needs of handicapped children for possible inclusion in the revised Mental Health State Plan.

9. To cooperate with the Department of Education and local school divisions in providing them with written procedures that are required when considering the admission of handicapped children to facilities operated by the Department of Mental Health and Mental Retardation.

The Department of Education agrees to the following:

1. To provide appropriate special education services through local school divisions for those children identified and diagnosed as being emotionally disturbed or mentally retarded.

2. To provide appropriate education for emotionally disturbed children ages 2-21 within mental health facilities operated by the Department of Mental Health and Mental Retardation in accordance with Board of Education regulations.

3. To provide supervision of special education programs conducted within State mental health and mental retardation facilities.

4. To provide consultation regarding available special education curriculum materials for programs conducted for handicapped children in State mental health and mental retardation facilities.

Funding Sources:

The implementation of this agreement is contingent upon the availability of appropriate funding for the above referenced services.

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Leo E. Kirven, Jr., M. D.
Commissioner

July 18, 1979
Date

S. John Davis, Ed. D.
Superintendent of Public Instruction

12-18-79
Date

Approved by:

Jean L. Harris, M. D.
Secretary of Human Resources

1-11-80
Date

Approved by:

J. Wade Gilley, Ph. D.
Secretary of Education

1.9.80
Date

INTERAGENCY COOPERATIVE SERVICES AGREEMENT
BETWEEN
VIRGINIA DEPARTMENT OF EDUCATION
AND
DEPARTMENT OF WELFARE

DRAFT

This interagency cooperative services agreement is made and entered into by S. John Davis, State Superintendent of Public Instruction, and William L. Lukhard, Commissioner of the Department of Welfare.

The purpose of this agreement is to provide for maximum coordination and utilization of services of each Department in order to be consistent with the Revised State Plan for the Identification and Diagnosis of Children Who Are Handicapped.

The provisions of this agreement shall reflect the policies of the Department of Welfare and the Department of Education, and shall become effective upon the date signed by the Commissioner and the Superintendent. This agreement shall terminate in one year subject to renewal with or without amendments. This agreement may be amended subject to mutual consent of the parties, provided that such changes are stated in writing to the other party 30 days prior to the effective date of such changes. Federal and/or State regulations or laws may be imposed which would necessitate changes or amendments.

A. The Department of Welfare Agrees to the following:

1. To assist local welfare departments in the referral of children (ages 0-5) through the Early and Periodic Screening, Diagnosis and Treatment Program, to local health departments for the purpose of diagnosing and identifying handicapped children.

2. To assist local welfare departments in the appropriate referral/placement of suspected/identified handicapped children under their care in accordance with Regulations and Administrative Requirements for the Operation of Special Education Programs in Virginia.

3. To assist local welfare departments in their understanding of the characteristics and needs of handicapped children through information and training.

4. To develop and implement a plan for the training of foster parents caring for handicapped children.

5. To provide, through local welfare departments, information on all services and financial programs available to the handicapped child and family.

6. To cooperate in the transfer of information concerning handicapped children between departments, consistent with State and federal laws.

7. To develop a system for a rate structure for services to handicapped children in foster care facilities and to cooperate in the negotiation of rates for various residential facilities serving handicapped children.

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B. The Department of Education Agrees to the following:

1. To provide appropriate special education and related services through local school divisions and State operated programs and facilities for those children identified and diagnosed as handicapped.

2. To share appropriate information with the Department of Welfare in conformity with the Management of Student's Scholastic Record in the Public Schools of Virginia.

3. To cooperate in the approval of private educational facilities for handicapped children in the care of welfare.

4. To assist the Department of Welfare in the implementation of the plan for understanding and training of department personnel, foster parents, etc., responsible for handicapped children in accordance with Regulations and Adminstrative Requirements for the Operation of Special Education Programs in Virginia.

5. To cooperate in the development of a system for a rate structure for services to handicapped children in foster care facilities and to cooperate in the negotiation of rates for various residential facilities serving handicapped children.

C. Funding

The implementation of this agreement is contingent upon the availability of appropriate funding for the above referenced services.

S. John Davis, Ed. D.
Superintendent of Public Instruction

Date 12-18-79

William L. Lukhard, Commissioner
Department of Welfare

Date

J. Wade Gilley, Ph. D.
Secretary of Education

Date 1-4-81

Jean L. Harris, M. D.
Secretary of Human Resources

Date 1-11-80

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Procedures for implementing the agreement between Maternal and Child Health Service and the Section for Special Education as they relate to the Missouri Valley Regional Maternal and Child Health Office

Maternal and Child Health Services, Department of Health and the Section for Special Education, Division of Elementary and Secondary Education, have made an agreement to coordinate their efforts toward the success of the Rural Screening Clinics. The two offices will be working jointly in identification and follow-up of children who are eligible for education of the handicapped.

Upon completion of each screening, the rural screening team will make referrals to parents of each identified child and to all other appropriate agencies, as determined necessary by the rural screening team. For those children identified as having an educational problem, referrals will be made to their respective school districts and the Section for Special Education also.

Referral and follow-up procedures for the Section for Special Education and local school district (LEA) are outlined below:

MCHS - Missouri Valley Region will:

1. Send all educational referrals to the identified child's parents, school district, and the Section for Special Education.

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Section for Special Education will:

1. Receive a copy of all educational referrals from MCHS.
2. Place name of referred child in his/her respective school file.
3. File referral in the Special School Placement file.
4. Contact a regional representative, such as Direction Services or Association for Retarded Citizens, to conduct follow-up on all educational referrals. This may be done through verbal or written contacts with the child's parents and/or school district.
5. Inform MCHS of all follow-up conducted and the results of it.

Local School Administrators will:

1. Make referrals for screening to their community health nurse or local health facility.
2. Determine whether to send one or more school personnel to attend all or part of the rural screenings and/or staffings.
3. Receive a copy of educational referrals from MCHS.

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Refer to the South Dakota Administrative Special Education Handbook for the following procedures:

4. Determine appropriate evaluation and source of funding (recommendations may be on referral and clarification may be obtained from rural screening team),

5. Within 30 days organize a placement committee meeting with the parent(s) of the child, the evaluator or someone to interpret the evaluation data, an administrator, a special education teacher, and any support services,

6. Through the placement committee, write an individual educational program (IEP) for the child, and

7. Through the placement committee and the IEP, determine the appropriate educational placement and place the child.

APPENDIX C

RESOURCES FOR IMPLEMENTATION OF CHILD FIND

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Media Resources

TV Stations - Including Cable Announcement and News Stations
Radio Stations - Talk Shows, Sports, Announcements
Major and Local Newspapers
Publications or Newsletters
Community Publications
Local Company or Business Publications
School Publications
Other Agency Publications - Espically those working with the handicapped
Bulletin Boards - Post Office, Grocery Stores, Laundromats, etc.
Bus Ads
Billboards
Store Front Displays
Awareness Days
Fliers and Brochures
Posters
Slide - Tape Presentations/Public Speaking

Agency Resources

Medical Associations - Including Dentists
Ethnic Organizations
Parent Groups
Service Groups
Fraternal Groups
Social Service Organizations
Day Care Centers and Nurseries
Public Health Agencies
Social Services Agencies
Child Development Clinics
Mental Health Counseling Centers
MH/MR Community Service Boards

Community Resources

Welcome Wagon Kits
Physicians Offices - Pediatricians, Obstetricians, General Practitioners, Opthamologists, Neurologists
Churches and Clergymen
Postmen - Rural Routes
Military Bases
Major Employers - Including Banks and Utility Companies

APPENDIX D

SCREENING

The purpose of screening is to identify all children who would benefit from special education services. It is a process to determine whether a child should be referred for indepth assessment, and should not be confused with diagnosis, assessment or evaluation, as it may become too costly. It is a brief, first step measurement activity which should be fast, efficient and economical and should only indicate that the child is in need of further evaluation. Further, a child should never be labeled or referred for services solely on the results of screening.

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TYPES OF SCREENING

Screening may be individual or massed (community). Massed screening is utilized to seek out children who may require assessment and special services and is usually done at an educational or health care setting, such as a Head Start day care center, with the time and place announced and advertised to the public. Individual screening, on the other hand, is ongoing and may be done in the home or in an educational or health care setting.

For a massed screening, the following steps are recommended:

1. Identify existing resources - eliminate duplication, coordinate services and/or personnel.
2. Select a screening coordinator - one person should be responsible for the development and coordination of the screening program.
3. Establish a planning committee - for assistance in planning and implementation, from various personnel/agency resources.

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4. Name target population - geographic location, age range, eligibility requirements, how many children.
5. Determine areas to be screened - e.g., developmental, speech/language, hearing, vision, social/emotional, health.
6. Select screening instruments.
7. Determine who will administer each portion of the screening - may include paraprofessionals, volunteers and parents.
8. Arrange time and place.
9. Plan procedures for public awareness - timelines and methods.
10. Implement public awareness program.
11. Train screening personnel.
12. Implement screenings.
13. Data Interpretation - immediate feedback to parents or through letter or future conference.
14. Collect and anlyze data - interpret for each child to identify those to be referred for assessment.

This process may also be modified for use in individual screening programs.

In most cases, both types of screening utilize a standard screening instrument. However, in the case of an infant with a very severe or obvious handicap, an instrument may not be used. "Eyeball" screening suffices, and the child is referred directly for assessment. This may also be accomplished through a telephone conversation with a parent, where it becomes obvious that the child requires assessment. With the more mildly handicapped child, screening and assessment are usually two distinct steps in the process of identification.

WHO REFERS FOR SCREENING?

Referrals may come from a wide variety of sources. The more imaginative the LEA has been in informing the community through Child Find public and professional awareness (see Appendix C), the wider the range of referral sources. Referrals for individual screening typically come from a parent, professional or agency. Referrals may also come from primary health care providers, clinics, social services programs and general community sources, such as neighbors, postmen and clergymen.

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WHO SCREENS?

One person should be designated by each LEA to coordinate all screening activities. Persons who do the actual screening may be parents, teachers, paraprofessionals, health professionals, child care workers, and other volunteers. These people must, however, be trained to use the particular screening instrument(s) by a professional who is familiar with and has used the instrument(s). These professionals may be educational specialists or supervisors, psychologists, speech therapists and others knowledgeable about screening instruments. It is important to emphasize that it is usually not economical to use professionals for the actual screening and that their time will be more efficiently used to train others to screen because of the large numbers of children. Interagency coordination may be very helpful in the area of planning for screening and actually training people to screen (see Appendix B).

It may also be helpful for the LEA to develop a citizens advisory board or council, in order to maintain community interest in screening efforts and to make sure the community is aware of screening plans. People serving on the screening advisory board may be parents of handicapped children, representatives of agencies serving pre-kindergarten children and other interested people within the community.

COMPONENTS

The screening for each child should include the following components:

1. Information including the age at which developmental milestones were attained.
2. Results of previous assessments and evaluations.
3. History of treatment received for disabilities.
4. Cognitive and/or speech/language functioning - receptive and expressive.
5. Gross and Fine Motor functioning.
6. Social/emotional/behavioral functioning.
7. Self-help skills, when applicable.
8. Observation of the child in home or educational setting.

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Items one through three may be obtained from the parent or guardian either through interview or written form. Items four through seven are usually covered by administering a general standardized screening instrument. Item eight is usually accomplished during the administering of the screening instrument. Some instruments, however, may only require information from someone knowledgeable about the child, and in these cases, the screener should make a point to observe the child. Therefore, the screening consists of:

A. A brief parent interview or form.
B. Administering of standardized developmental screening instrument.
C. Observation of the child.

If possible, it is also desirable to administer or review the results of both a visual and auditory screening. This may be practical for a massed screening, but not for individual screening, unless the child obviously requires them. In any case where a child is suspected during the screening of having a visual or auditory problem, but tests cannot be administered, the screening report should include a recommendation for assessment in these areas. Experienced screeners should use their discretion in deciding what instruments to administer during the screening.

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SCREENING INSTRUMENTS

A screening instrument should be chosen with several criteria in mind:

- It should be standardized (should compare the child with the general population).
- It should be easily, quickly, and economically administered (cost effective).
- It should accurately sort out children who need further study with as few mistakes as possible (valid and reliable).
- It should be acceptable to the professionals who may be doing follow-up assessment.
- It should address all or most of the areas mentioned above as components of a screening.

It is advisable for the LEA to choose one standard screening instrument to use for all children. This will facilitate ease in training of screeners, administering the instrument, and reporting the results. The LEA should be careful not to use assessment instruments for screening because it will be costly and time consuming.

An educational agency which has developed its own screening instrument may use it if it meets the criteria outlined above. If one has not been developed, it is advisable to use an instrument which has already been developed and proven effective, rather than go to the expense and time to develop one. Available instruments usually will meet the LEA's needs. Appendix F provides guidance in this area.

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THE SCREENING REPORT

The report should be a brief report summarizing the results of the screening, written by the person who screened the child. It should include the following:

1. A brief summary of the information reported by the parent or guardian. (If a form is used, it may simply be included.)
2. A brief summary of the results of the screening instrument.
3. A short description of the observation of the child.
4. Recommendations

The recommendations are the most important part of the screening report, and should be written only by the screening coodinator or their designate. The recommendation may be one of three alternatives:

1. No services are indicated at this time.
2. The child should be re-screened at a later time (state length of time).
3. The child should receive further assessment.

For alternative three, any areas of assessment that need special attention should be noted (e.g. visual, speech, etc.). If the screener is in doubt as to which alternative to report, the child should be referred for complete assessment.

The entire report may be very brief and complete instrument results may be attached. Screening results which indicate further assessment or no services at this time should be reported to the home school ARD for further action or filing. Results which indicate screening at a later date should be returned to the screening coordinator. These results should be shared with cooperating agencies so that the child may be tracked as closely as possible. All screening reports, regardless of result, should be maintained by the screening coordinator.

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EVALUATION OF SCREENING ACTIVITIES

Each LEA should evaluate the effectiveness of the screening process. Data should be maintained and compiled by the screening coordinator which shows how many children have been referred for screening, the source of referral, how many have been screened, how many have been referred for further assessment or are being tracked, and how many of those assessed are subsequently labeled for service. Cost analysis data should also be kept. Examples of this are provided in the model screening programs presented at the end of this appendix.

As a result of the statistical and cost data, the LEA should determine whether any changes are necessary in the screening process (e.g. change in screening instrument, change in the training of screeners, etc.). At this point, if the educational agency has any agreements with other agencies, interagency cooperation will be necessary so that the changes will be effective and economical for all.

PARENT INVOLVEMENT

If the child is going to be involved in a formal "hands on" screening (e.g. administering of a screening instrument and/or an observation) the parents' written permission should be obtained. In addition, it is advisable for the screener to consult with the parents in gathering information as well as to explain the screening procedure to them. It should be explained to the parent that screening will not be used to label the child or to develop an IEP, and that the child will not be diagnosed or placed in special education based on the results. Other things to explain to the parents are:

- The reason for the screening request, if someone other than the parent has requested the screening.
- Who will actually screen the child.
- The procedures to be used (what instruments, etc.).
- How the findings will be used and who will use them.
- The assurance of their full involvement in the results of the screening.

It may be advisable to include these things on the written permission form. The screener should also utilize the parent as fully as possible in collecting information on the child. Finally, the parents should receive a copy of the screening report from the screening coordinator with an explanation of the next action, if indicated. At this point, the screening coordinator may wish to refer the parent to other agencies, if the educational agency is not going to continue following the child, and a need is apparent for another type of service.

MODEL SCREENING PROGRAMS

Following are several models, which have been excerpted from the following source:

> Ramey, C. & Trohavis, P. Finding and educating the high-rish and handicapped infant. Chapel Hill, N.C.: Technical Assistance Development System (TADS), 1980.

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CHILD DEVELOPMENT RESOURCES INFANT PROGRAM/OUTREACH PROJECT

Lightfoot, Virginia

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BACKGROUND AND PROGRAM OVERVIEW

This community screening program known as (Child Check) grew out of the Early Identification Project, which was funded by a grant from the Virginia State Department of Developmental Disabilities from 1973 to 1975. So many infants were identified during the two years of the proejct that a comprehensive identification system was developed with four contact strategies: (1) Child Check (community screening), (2) media public service announcements (newspaper, radio, posters), (3) physicians/hospital referrals, and (4) surveys.

Since the community served is multi-county ranging from very rural to sophisticated urban, Child Check goes into the community every spring to screen infants from birth to 2. Places are identified where large numbers of people frequent, (i.e., theatre lobbies, shopping centers, schools, churches, social services offices, etc.) and at key times of the day and wekk (lunch, early evening on Friday or Saturday) Child Check staffers administer the Prescreening Denver Questionnaire and other appropriate tools for vision, hearing, and speech problems. The Denver is scored on the site with parents given results immediately. If the child fails, a recommendation is made for a further, in-depth screening at another date and site using the whole Denver.

Current funding sources for the Child Check program are: the state (60 percent), United Fund (20 percent), public contributions (10 percent), and private contributions (10 percent).

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Target Audience for Screening: Infants

- Obstetric complications
- Low birth weight
- Postnatal illness
- Prematurity
- Physical anomalies
- Neurological problems
- Developmental problems
- Sensorimotor problems
- Environmental hazards
- Multiple factors

Conditions, Environmental Insults, Genetic Traits, or Handicaps being Screened

Development delays, vision/hearing losses, and speech impairments

Cost Data

The following cost data are based on serving approximately 100 children:

1. Approximately $2.42 per child without mailing evaluations and results to parents first class.
2. Approximately $3.97 per child with mailing evaluations and results to parents first class.
3. Cost will vary depending on:
    a. amount of postage
    b. number of paid staff
    c. all other costs are minimal
4. These costs include one speech therapist at $20.00 per day and 20 hours of staff time to coordinate, train and do follow-up. Once a core of volunteers has been trained, costs are reduced since future training can be done by volunteers with minimum staff supervision.
5. This estimate does not include staff time for follow-up home visits. It does presume Denver rescreening.

Services/Training/Materials Available

Child Find: A Manual. Describes the process of locating and identifying children who are handicapped, suspected handicapped or at-risk. Techniques include community education, use of the media, involving the medical profession, surveys, interagency relations, and community screening.

FOR MORE INFORMATION, CONTACT:

Corinne Garland, Executive Director
Child Development Resources Infant Program/Outreach Project
Child Development Resources
P.O. Box 299
Lightfoot, Virginia 23090

PROJECT RHISE OUTREACH
CHILDREN'S DEVELOPMENT CENTER
ROCKFORD, ILLINOIS

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BACKGROUND AND PROGRAM OVERVIEW

Project RHISE was originally funded under the HCEEP to develop a model for service delivery to handicapped and developmentally delayed infants and their parents in an urban, multicounty area. Now in its sixth year, the project focuses on outreach -- providing training and technical assistance to those replicating the model or adapting it to meet their service needs.

One component of the RHISE model is screening, which is accomplished three ways. First, children referred to the program are screened to determine their need for an in-depth assessment (prior to program entry). Some children with clearly demonstrated disabilities bypass the screening process and go directly into in-depth assessment. Second, children in high-risk groups are routinely screened. These include all graduates of the neonatal intensive care unit at the local hospital, all children identified as having high levels of lead in their blood, and children living in economically depressed areas who are considered at risk for developmental delay. Third, mass screening efforts are made three to four times a year using such methods as publicizing free screening at shopping centers and in conjunction with pre-school and public school registration.

Funding sources for screening are: the state (45 percent), local agencies (40 percent), fees (11 percent), and private contributions (4 percent).

Target Audience for Screening: Infants

Indicators of Risk:

Obstetric complications
Low birth weight
Postnatal illness
Prematurity
Physical anomalies
Neurological problems
Developmental problems
Sensorimotor problems
Environmental hazards
Multiple factors

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Conditions, Environmental Insults, Genetic Traits, or Handicaps being Screened

Screening is for delays in development, many could be due to any of the full range of handicapping conditions, environmental factors, miscellaneous genetic traits, or health impairments.

Evidence of Effectiveness

A Statistical Summary Report can be obtained from Project RHISE which details both children's progress and parents' progress. Screening data from the Denver Developmental Screening test is also availabe in written report.

Mass Screeing Costs

The cost data in Table 3 are based on a model which has the following allowances per child screened:

- 20 minutes for actual screening
- 10 minutes for the individual administering the screening to write the report
- 10 minutes for the secretary to type and file reports
- 5 minutes for the client coordinator to do scheduling, etc.
- 4 minutes for the media coordinator to do advertising and public relations

Table 3

Costs for Mass Screening by Project RHISE

Basic*	Cost of Screening by Administrator			
Costs by DDST Outcome	Aide $1.56	B.S. Teacher ($2.85)	M.S. Teacher ($3.68)	Volunteer (-0-)
Pass ($1.57)	$3.13	$4.42	$5.25	$1.57
Fail ($2.21)	$3.77	$5.06	$5.89	$2.21

*The basic cost figure includes materials and secretarial, client coordinator, and media coordinator time. It is considered a fixed amount per child screened. It does not include either the initial investment in the permanent equipment and materials needed to the DDST or the cost of training volunteers.

The recommended initial investment in permanent equipment and materials to do the DDST on a mass screening bais is 16 Denver Kits, 16 Denver Instruction Manuals, 1 Instructor's Manual, and 1 Proficiency Manual. Volunteers can be trained with these materials.

The cost of initial investment in materials is approximately $152.50. The cost of training volunteers, based on a workshop with 15 participants, is approximately $7.10 per volunteer.

The model costs assume that screening is done at the program. If they are done at another site, transportation costs must be added, as well as additional salary for traveling personnel.

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Individual Referral Screening Costs

The cost dat in Table 4 are based on a model which has the following allowanced per child screened:

- 30 minutes for actual screening
- 30 minutes for the individual administering the screening to write the report
- 30 minutes for the secretary to type and file reports
- 30 minutes for the client coordinator to make contacts, schedule the screening, etc.

Table 4

Costs for Individual Screening by/Project/RHISE

Basic Costs by Test Outcome	Cost of Screening by Administrator		
	Aide ($ 3.11)	B.S. Teacher ($ 5.69)	M.S. Teacher ($ 7.35)
Pass all areas of DDST ($6.20)	$ 9.31	$11.69	$13.55
Fail one area of DDST ($7.75)	$10.86	$13.44	$15.10
Fail two areas of DDST ($9.30)	$12.41	$14.99	$16.65
Fail three areas of DDST ($10.85)	$13.96	$16.54	$18.20
Fail four areas of DDST ($12.40)	$15.51	$18.09	$19.75

*The basic cost figure includes materials and secretarial and client coordinator tiem. It is a fixed amount per child screened. It does not include the inital investment in permanent equipment and materials needed to do the Denver Developmental Screening Test. The initial investment is $6.25 for each Kit and $3.00 for the Instruction Manual.

Services/Training/Materials Available

Workshop Training Format for the Denver Development Screening Test.

The format for a six-hour workshop in the use of the DDST is available for use in training paraprofessionals and volunteers in the community to screen children for potential developmental difficulties.

For More Information, Contact:

Sue Wilke, Training Coordinator
Project RHISE/Outreach
Children's Development Center
750 North Main Street
Rockford, Illinois 61103
(815) 965-6745

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APPENDIX E

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ASSESSMENT

For complete information on general assessment guidelines and requirements, the reader should refer to Protection in Evaluation: Procedures for Assessing Students (Maryland State Department of Education, Special Education Division, 1980). This section focuses on assessment issues particular to the birth to three population.

Parent Involvement

Including the parent(s) in the evaluation of the infant is critical. First, it is helpful to the examiner to have the parent present during the formal assessment, since the child will be more comfortable and willing to perform. In some instances, it is even advantageous to place the child on the mother's lap during the examination to provide security for the child. If the child is not cooperating or not performing up to potential, the mother can report what the child is capable of doing under normal circumstances. Occasionally, the examiner may wish to have the mother elicit responses from the child.

Secondly, a measure or observation of the mother-child interaction is an important component of the assessment. Because the parents are the primary caregivers and the child is so developmentally pliable during the period of infancy, an indication of the mother's patterns of caregiving and the child's own initiation of and responses to interaction will be important in diagnosing the child's problem and subsequently planning for intervention procedures. This may be done by observing the mother and child as they interact during the assessment, or can be done more formally by asking the mother to play with the child or teach the child and record mother and infant behaviors on a checklist of responses. The Caldwell Home Inventory is an example of such a scale.

Third, the assessment should include a developmental history of the child, and the parent is the best source for this information. Parents may also have medical information and other information compiled by various agencies who have seen the child.

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Location of Assessment

The location depends on several factors: 1) type and severity of the child's disability; 2) geographic location of the school (rural, suburban, urban); 3) available resources in the school and community; 4) parents preferences; and 5) funding sources. It is important, however, that the assessment takes place in a setting that is familiar and comfortable for the child, so that the best performance may be elicited.

Occasionally, however, in the case of a severely or multiply impaired infant, it may be necessary to bring th child to a clinic or center where he/she may be seen by a multidisciplinary team for assessment. Children with mild or moderate problems should be assessed by community or school-based professionals who are more likely to understand the socioeconomic culture and environment of the child, and be involved in an early childhood network, having the potential to be involved in the future progress of the child.

The Multidisciplinary Team

All the professionals who deal with handicapped children have the potential of being involved in the assessment of children aged birth to three. Because it is impractical in most cases to have many persons assess a child in all areas of development, it is suggested that the child be assessed only in areas of suspected developmental problems. The Bylaw requires that the child receive an appropriate educational assessment in the areas of reading, math, spelling, written and oral language and perceptual motor functioning, as appropriate. Because the first three or four of these areas are not usualy appropriate for the infant or young child, a formal cognitive or developmental measure such as the Bayley Scales or the Cattell, will serve to fulfill this requirement. These measures must be administered by a person qualified to do so. In some cases, a less formal instrument may provide information on the child's development in most areas of functioning, which may be given by educational specialist.

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Beyond this primary component, other professionals should participate in the assessment as indicated by the child's problems. This may include physical therapists, occupational therapists, speech therapists, medical personnel, hearing or vision specialists, social workers, and any other professional or specialist who may be able to contribute to the diagnosis of and planning for the child.

Components of the Assessment

The following components are suggested for the assessment of the birth to three handicapped child:

1) A formal or information instrument which measures the child's development in most areas of functioning (as described above).
2) A developmental history, including developmental milestones, medical history, and any previous intervention efforts, educational or otherwise.
3) A formal or informal observation of parent-child interaction, including an appraisal of the general home environment.
4) Any other special assessments needed for a complete evaluation of the child, such as physical, medical, speech and language, hearing, vision, etc.

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Special Considerations

There are several considerations that must be taken into account when assessing a very young handicapped child. The examiner should bear the following things in mind before and during the assessment:

a. State Considerations - the infant's state (drowsy, awake and alert, active, etc.) must be taken into consideration for assessment. What has occured before the assessment, such as naps or feedings, will affect the infant's ability to perform to potential. Tolerance varies greatly from infant to infant, and special considerations such as medications, and seizures should be voted and accounted for.

b. Response Style - The examiner must pace the assessment according to the baby's response style. For example, a child with cerebral palsy may process slowly so that more time is needed for items. Other babies may satiate very quickly so that the examiner must move along at a fairly rapid pace.

c. Contextual Considerations - The examiner must have a feel for the child's distractibility. Young children may respond to certain types of visual stimulation such as patterns, bright objects, and contrasts (be sure that the child is attending to the proper stimuli, rather than your shiny necklace or checkered blouse!). It is usually good practive to present test objects one at a time, with the others hidden, so that the child can focus their attention on the task.

d. Response Limitations - The examiner must identify the child's mode of response. For example, a physically handicapped child may not be able to complete a response even though they may understand the concept. Visually or hearing impaired children may also have different modes of response. The examiner must take these limitations into consideration in order to determine the child's true level of functioning. The conditions of the assessment (child's limitations, prompts given for test items, etc.) should be noted in the assessment report, stating whether the examiner feels that the child's full abilities have been tapped.

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e. Positioning - The positioning of both the child and the test materials is important. A physically handicapped child must be positioned so that the maximum response can be facilitated. For example, the chair should fit the child, their feet should touch the floor, and careful positioning can inhibit extension patterns which may inhibit proper responses. Materials for testing must be placed so that the child can easily regard them and touch them if required. For example, a child with cerebral palsy who cannot move his/her eyes vertically will not be ablt to follow the trajector of a falling object. This could be mistaken as the lack of a particular concept.

f. Maintaining Interest and Performance - The examiner should balance the failures and successes during the assessment to keep the child motivated and not frustrated. This will also insure that the parent does not become discouraged.

Assessment Instruments

The following instruments are designed specifically for the assessment of very young children. The instruments vary in purpose, age range, and areas of assessment, so that they should be thoroughly examined by LEA's before use in order to assure that they will be used properly by qualified examiners.

- Brazelton Neonatal Behavioral Assessment Scale
- Bayley Scales of Infant Development
- Cattell Infant Intelligence Scale
- Caldwell Home Inventory
- Milani - Comparetti Developmental Screening Test
- Denver Developmental Screening Test (DDST)
- Denver Prescreening Developmental Questionnaire (PDQ)
- Alpern - Boll Developmental Profile
- Boyd Development Progress Scale
- Neonatal Perception Inventory
- Carey Infant Temperament Questionnaire
- Erickson's Parent-Infant Care Record
- Washington Guide to Promoting Development in the Young Child
- Denver Eye Screening Test (DEST)
- Denver Articulation Screening Exam (DASE)
- Denver Audiometric Screening test (DAST)
- Gesell Developmental Schedules
- Learning Accomplishment Profile
- McCarthy Scales of Children's Abilities
- Portage Guide to Early Education
- Preschool Attainment Record

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Additional references are offered in Appendix F.

APPENDIX F

SCREENING AND ASSESSMENT INSTRUMENTS

Included here is the list of screening and assessment instruments for the birth to five year population, which are available for loan to local education agencies and other cooperating agencies from the Maryland State Department of Education (MSDE), according to Section 3.3.2 and 4.3.2 of the plan. MSDE does not necessarily endorse these instruments, however, would like to make them available for trial use and examination so that LEAs can make their own decisions as to which instruments to choose for consistent use. A matrix has been provided which lists the author and publisher, the purpose and description, the age range and disability, the examiner qualifications and other pertinent information regarding each instrument.

Additionally, this list of instruments is by no means complete, and LEAs are encouraged to examine as many screening and assessment measures as possible. The following resources may provide more detailed information on a larger number of instruments:

Test Analyses: Screening and Verification Instruments for Preschool Children (3 Volumes). Pennsylvania State Department of Education, Harrisburg, 1977, 1980. (Also available through ERIC).

Early Childhood - Identification and Assessment, 1977 Topical Bibliography No. 702, CEC Information Services and Publications, Reston, Virginia.

Perspectives on Measurement (from: A Collection of Readings for Educators of Young Handicapped Children, edited by Talbot Black). Technical Assistance Development System (TADS), Frank Porter Graham Child Development Center, University of North Carolina, Chapel Hill, 1979.

Evaluation Bibliography: Parent Child Decision Makers - Tadscript #2. Distributed by: Instructional Materials Center, 1020 South Spring Street, Springfield, Illinois, 62706.

Gallagher, J.J. and Brodley, R. Early Identification of Developmental Disabilities, Yearbook of the National Society for Study for Education. Part II (Vol. 71). Chicago: University of Chicago Press, 1972.

Grim, J. (Ed.) Evaluation Bibliography. Chapel Hill: TADS, 1973.

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Birth - Five years Screening and Assessment Instruments - MSDE

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1. Animal Crackers
2. Bayley Scales of Infant Development
3. Behavioral Characteristics Progression
4. Bender Visual Motor Gestalt Test
5. Brigance Diagnostic Inventory of Early Development
6. Carolina Developmental Profile
7. Denver Developmental Screening Test
8. Developmental Test of Visual Perception
9. Environmental Language Inventory
10. Environmental Prelanguage Battery
11. Goldman - Fristoe - Woodcock Test of Auditory Discrimination
12. Hawaii Early Learning Profile (HELP)
13. Kindergarten Auditory Screening Test
14. Learning Accomplishment Profile (LAP)
15. Lindamood Auditory Conceptualization Test
16. McCarthy Scales of Children's Abilities
17. McCarthy Screening Test
18. Minnesota Preschool Scale Form A
19. Motor-Free Visual Perception Test
20. Peabody Picture Vocabulary Test - Revised Forms L and M
21. Portage Guide to Early Education
22. Preschool Attainment Record (Research Edition)
23. Preschool Language Scale
24. Preschool Language Screening Test
25. Progress Assessment Chart of Social and Personal Development - Form P (PAC)
26. Psychoeducational Evaluation of the Preschool Child
27. Quick Neurological Screening Test
28. Wechsler Preschool and Primary Scale of Intelligence (WPPSI)

Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Animal Crackers	Adkins/Ballifi CTB/McGraw Hill 1973	Screening To provide information regarding a child's motivation to learn and achieve. Looks at non-intellectual oriented behaviors (school enjoyment, self-confidence, purposiveness, instrumental activity and self-evaluation). Scores may be converted into percentile rankings.	Preschool-Grade 1 - All disability groups. Prerequisite skills: Knowledge of left and right. Not recommended for bilingual children.	Knowledge of instructions in manual and should be sensitive to the child's reactions and rapport.	1 Administration Booklet Examiner Manual Missing 1 Consumable Individual Performance Record
Bayley Scales of Infant Development.	Bayley The Psychological Corporation. 1969	Assessment The Mental Scale assesses sensory perceptual acuities, discriminations, and ability to respond. The Motor Scale measures the degree of control of body coordination of the large muscles and manipulating skills of the hands and fingers. The Infant Behavior Record assesses the child's social and objective orientations toward his environment. Scores may be compared to norm tables to get a mental and Psychomotor Developmental Index or an age equivalent.	CA: 2-30 months - All disability groups.	Should have experience in testing infants of all ages, and be able to effectively interact with infants at various levels of development. Should be thoroughly familiar with the directions and scoring procedure.	Test materials complete. Consumable record forms. Materials not provided: 8 common items.

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Behavioral Characteristics Progression (BCP)	Santa Cruz Special Education Management System. VORT Corporation 1973	Screening Nonstandardized, criterion referenced to help a teacher identify which behaviors to focus upon within the basic areas - Self Help, Perceptual Motor, Language, Social Academic, Pre-vocational and Vocational. May be used to determine a child's present performance levels, as well as short term objectives.	Age range not specified - All disability groups.	Must be familiar with the child's habitual behavior and performance and must have good observational skills. May be the classroom teacher.	Contains one BCP Binder, 3 sets of BCP charts and 2 BCP observation booklets.
Bender Visual Motor Gestalt Test	Bender American Orthopsychiatric Assoc., Inc. 1946	Screening/Assessment Designed to detect visual perceptual difficulties and the possible presence of brain damage. Child is asked to reproduce (draw) 9 figures, and each figure is analyzed in accordance with specific criteria.	CA: 4yrs. - Adult All disability groups. Preprequisite Skills: ability to copy forms.	No specific training necessary to administer. The person interpreting the reproduced figures should be knowledgeable about the scoring criteria.	1 Manual Consumable Record Forms Figure Cards Missing.
Brigance Diagnostic Inventory of Early Development	Brigance Curriculum-Associates 1978	Screening/Assessment Criterion and Normative Referenced. Determines developmental level and strengths and weaknesses in the areas of psychomotor, self-help, speech and language, general knowledge and comprehension, and early academic skills.	Developmental Age - Birth to 6 yrs.	Can be given by a paraprofessional with professional supervision.	1 Manual, including laminated pages. 8 Developmental Record Books (Consumable) Some test items require materials commonly found in the home or classroom.

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Carolina Developmental Profile	Lillie & Harbin Kaplan Press 1977	Screening Criterion referenced behavior checklist designed to be used with the Developmental Task Instructional System. Designed to assist teacher in establishing long range objectives in fine motor, gross motor, visual perception, reasoning, receptive and expressive language.	CA: 2-5 yrs. for the mildly impaired.	Should be familiar with items. Designed for use by classroom teacher.	9 copies (consumable) Materials not provided: 17 common items including toys (listed in manual).
Denver Developmental Screening Test	Frankenburg, Dodds, Fandal, Kazuk and Cohrs LADOCA Project and Publishing Foundation, Inc. 1975.	Screening To aid in the early identification of children with developmental problems. Sub-areas include personal-social, fine motor-adaptive, language and gross motor. Tests are judged as being normal, abnormal, questionable or untestable.	Birth - 6 yrs. - All Disability Groups.	No Special Training Required. Parent may accompany child.	1 Reference Manual Consumable Test Forms. Kit materials missing but can be substituted.
Developmental Test of Visual Perception	Frostig, Lefever, Whittlesey Consulting Psychologists Press 1966	Screening/Assessment Designed to help identify children needing perceptual training. Sub-areas include Eye/Hand Coordination, Figure - Ground, Constancy of Shape, Position in Space, and Spatial Relationship. Raw scores are converted to age equivalents and scaled scores. A perceptual quotient is yielded.	CA: 3-9 yrs. All disability groups. Adapted manual available for deaf and non-English speaking child.	Should be trained and observed by a qualified administrator, and thoroughly familiar with the test. Generally, should not be a regular classroom teacher.	Test Materials Complete Consumable Test Booklets. Materials not provided: pencils (colored) and paper.

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Environmental Language Inventory (ELI)	McDonald Charles E. Merrill Publishing Co. 1978	Assessment Provides information about the child's speech/language. Assists in determining child's understanding of the semantic rules of grammar. Yields scores for conversation, imitation and play.	CA: 2 yrs. - Adult. All Disability Groups and Normal Children.	Should be familiar with the intent and theory of the ELI so that spontaeous adaption may be made if necessary.	1 Manual Consumable Score Forms Materials not provided: 17 common items including toys (listed in manual).
Environmental Prelanguage Battery (EPB)	Horstmeier & McDonald Charles E. Merrill Publishing Co. 1978	Screening Provides diagnostic assessment of child prior to prescriptive training. Provides scores in Foundation for Communication, Early Receptive Language, Sounds, Single Words, and Beginning Social Conversation.	Any age individual who is functioning on the non-verbal level of communication development. All disability groups.	Designed for use by speech/language clinician. May be given by trained teachers, psychologists and parents. Examiner should be familiar with test procedures and have ability to be creative in administration.	Manual missing Consumable Score Forms Materials not provided: 22 common items including toys (listed in manual).
Goldman - Fristoe - Woodcock Test of Auditory Discrimination	Goldman, Fristoe and Woodcock American Guidance Service, Inc. 1970	Assessment Designed to provide measures of speech-sound discrimination. Includes a quiet sub-test and a noise sub-test. Scores may be converted to percentile ranks.	3.8 yrs - Senior Adult All Disability Groups.	Must be familiar with the manual and scoring and able to establish rapport with person being tested.	Test Complete Consumable Response Form Materials not provided: tape recorder, earphone sets.

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Hawaii Early Learning Profile (HELP)	Furuno, O'Reilly, Hosaka, Inatsuka, Allman, and Zeisloft. VORT Corporation 1979	Screening Provides a month to month sequence of normal developmental skills in the areas of cognitive development, language, gross motor, fine motor, social-emotional and self-help. Provides a comprehensive visual picture of the child's functioning levels.	Birth - 36 months. All Disability Groups.	No special training necessary. Examiner should be very familiar with the child.	1 Activity Guide 1 set HELP charts.
Kindergarten Auditory Screening Test	Katz Follet Publishing Company 1971	Screening To determine a child's ability to interpret auditory information. Sub-areas include speech in environmental noise, phonemic synthesis and same/different. Each subtest is scored as pass, fail or borderline.	Kindergarten-Grade 1 - Learning Disabled, Mentally Retarded, Hard of Hearing.	None	1 Manual and Record Consumable Response Books Materials not provided: Record Player.
Learning Accomplishment Profile (LAP)	Sanford Chapel Hill Training - Outreach Project 1974	Screening Designed to provide a record of the child's existing skills in the following areas: gross motor, fine motor, social, self-help, cognitive and language. A developmental age is determined and a change in rate of development may be computed.	1 month - 6 years. All Disability Groups.	Should be familiar with the LAP items. May be classroom teacher.	1 Manual Consumable Recording Book

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Lindamood Auditory Conceputalization Test (L.A.C. Test)	Lindamood & Lindamood Teaching Resources Corp. 1971	Screening/Assessment Designed to measure auditory perception. Tests isolated sounds in sequence and sounds within syllable pattern. Cut-off scores for grade levels K-12 are provided.	Preschool-Adult. All disability groups but hearing impaired. Modification for physically handicapped may be needed.	Should be familiar with the manual and the correct pronunciation of the the sounds and syllables.	Test Materials Complete Consumable Record Sheets.
McCarthy Scales of Children's Abilities	McCarthy The Psychological Corporation 1972	Assessment Assesses general intellectual level as well as strengths and weaknesses in important abilities. 18 subtests are grouped to form Verbal, Perceptual-Performance, Quantitative, Memory and Motor scales. An overall General Cognitive Index is computed on the basis of scores obtained on the Verbal, Perceptual-Performance and Quantitative scales.	CA: 2 1/2 - 8 1/2. All disability groups, especially children thought to be learning disabled. Prerequisite skills: Receptive & expressive language, motor abilities, ability to manipulate objects.	Should have clinical familiarity with the battery and experience with indivudal assessment of young children.	2 Complete Tests Consumable Record Forms and Drawing Booklets Materials not provided: 7 common items.
McCarthy Screening Test	McCarthy Psychological Corporation 1978	Screening To identify children who are likely to encounter difficulty in coping with school work. Sub-areas include right-left orientation, verbal memory, draw-a-person, numerical memory, conceptual grouping and by coordination. Scores are compared to percentiles and judged to be Pass, Fail or at Risk.	4 - 6 1/2 yrs. Learning Disabled Mildly Mentally Retarded	Teachers and paraprofessionals should be trained by professional experienced with the McCarthy Scales, including supervisor practice. Follow-up or referral decisions should be made by a professional.	Test Materials Complete Consumable Record Forms and Drawing Booklets Materials not provided: 4 common items.

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Minnesota Preschool Scale Form A	Goodenough, Van Wegenen & Maurer American Guidance Service, Inc., 1940	Screening/Assessment Investigates child's verbal and non-verbal intelligence in 26 sub areas. Scores may be converted to C-scores, percentile placements, or IQ equivalents.	CA: 2-6 years Mentally Retarded, Learning Disabled, Speech Impaired, Physically Handicapped	Should be able to establish rapport with the child and be thoroughly familiar with instructions for administration and item order.	Test materials complete. Consumable record forms. Materials not provided: 16 common items including toys (listed in manual).
Motor-Free Visual Perception Test (MVPT)	Hammill Academic Therapy Publications. 1972	Screening Tests child's visual perception ability regardless of motor involvement in the areas of spatial relationships, visual discrimination, figure-ground, visual closure and visual memory. Raw scores converted to a perceptual age and quotient.	CA: 5-7 years Physically Handicapped; Learning Disabled; Mentally Retarded; Test results from 4 year old children should be interpreted with caution.	No special training Classroom teacher Psychologist Education Specialist	1 manual 1 set of test plates Consumable score sheets
Peabody Picture Vocabulary Test-Revised (PPVT) Forms L and M	Dunn & Dunn American Guidance Service 1981	Screening/Assessment Tests Receptive Vocabulary Raw scores converted to age referenced norms or grade-referenced derived scores.	For persons 2 1/2 through 40 years who can see and hear reasonably well and understand English to some degree.	Must be familiar with test materials and manual prior to use. Practice in administering and scoring under supervision of experienced examiner encouraged. No formal coursework in tests and measurements necessary.	Test materials complete. Consumable Individual Test Records. One copy each of Forms L & M.

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Portage Guide to Early Education	Bluma, Shearer, Frohman and Hilliard The Portage Project Cooperative Educational Service Agency 1976	Screening Developed as a guide for teachers, parents, and other child care workers for assessing a child's behavior and planning curriculum goals. The PGEE is in checklist form with 580 developmentally sequenced behaviors in the areas of Infant Stimulation, Socialization, Self Help, Language, Cognition, and Motor. No quantitative score or developmental age is assigned.	MA: Birth- 6 years All Disability groups	Should be familiar with the checklist format. May be teacher aide, parent, etc.	18 Consumable Checklists Materials not provided: Items found in home or classroom.
Preschool Attainment Record (Research Edition)	Doll American Guidance Service, Inc. 1966	Screening To provide an assessment of children not readily accessible to direct examination due to sensory impairments, neuromuscular handicaps, speech and language difficulties, emotional disturbance, resistance or cultural differences which reflect environmental problems. Scores from the 8 subtests are totalled for a raw score which is converted to an Attainment Age and subsequently an Attainment Quotient.	CA: 6 months- 7 years All Disability Groups	Familiarity with item definitions and interview format essential. May be teacher or paraprofessional.	1 Manual Consumable Record Blanks missing

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Preschool Language Scale (PLS)	Zimmerman/ Steiner Charles E. Merrill Publishing Co. 1969	Screening To determine child's receptive and expressive language strengths and weaknesses in the areas of auditory comprehension and verbal ability. A language age and language quotient may be computed.	CA: 1 1/2 - 7 years Language level below 7 years. Speech impaired, language delayed, mentally retarded, emotional and behavioral problems, mild phyical handicaps, deaf.	Child Development Specialist Psychologist Speech Therapist Teacher Administrator	1 Manual 1 Picture Book 1 Consumable Scale Materials not provided: 5 common items
Preschool Language Screening Test	Hannah & Gardner Joyce Motion Picture Company 1974	Screening Designed to be a screening device for the purpose of identifying preschool children with a language deficit. Sub-areas consist of visual perception, motor development, auditory perception, and conceptual development. Normative data is provided for both middle and lower socio economic categories. Raw scores are converted to percentiles.	3-5 1/2 years Toddler Screening Section for ages 2 1/2 - 3 years	Professional in any field associated with preschool children.	Test materials complete Consumable score sheets and copy-me pages.

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Psycho-educational Evaluation of the Preschool Child	Jedrysek, Klapper, Pope & Wortis Grune & Stratton 1972	Screening Assesses child's present functioning and level of achievement in following areas: Physical functioning and sensory status, perceptual functioning, comprehension in learning for short-term retention, language comprehension, and cognitive functioning.	CA: 3-6 yrs. MA: 3-6 yrs. Developmental level must be adequate for age. Appropriate for difficult to test children, e.g. emotionally disturbed, behavior problems.	Should be familiar with items, probes, sequences, and materials. Examiner should be able to keep child in control and motivated.	1 Manual Consumable record sheets Materials not provided: 32 common items including toys (listed in manual).
Quick Neurological Screening Test (QNST)	Mutti, Sterling & Spalding Academic Therapy Publications 1978	Screening To identify children with learning disabilities. A total score is obtained by tabulating the scores on the 15 subtests and is judged to be High, Suspicious, or Normal.	Kindergarten (Age 5) through Grade 12 Appropriate for children suspected of being learning disabled.	Psychologist or person in helping profession. Should have administered a minimum of 25 QNSTs for practice and have excellent observation skills.	1 Manual Consumable Recording Forms
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)	Wechsler The Psychological Corporation 1967	Assessment Assesses the intellectual capabilities of the preschol child. The two sub areas of Verbal and Performance are divided into eleven subtests. Raw scores converted to scaled scores and IQ scores.	CA: 2-30 months All disability groups	Should have experience in testing infants of all ages, and be able to effectively interact with infants at various levels of development. Should be thoroughly familiar with the dirctions and scoring procedure.	Test materials complete. Consumable record forms. Materials not provided: 8 common items.

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Progress Assessment Chart of Social Personal Development Form P (PAC)	Gunzburg Aux Chandelles, P-A-C Dept. 1977	Screening PAC is a systematic observation instrument used to assess the social functioning of an individual with mental retardation. Sub-areas include self-help, communication, socialization and occupation (fine and gross motor). A Social Competence Index is computed for each subtest. The SCI is a comparison measure and the test does not yield a score.	CA & MA: 0-8 years. Mentally Retarded	Should be very familiar with scoring and summarizing procedures.	1 set of manuals (Vol. 1 & 2) 25 consumable Recording Sheets.

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Test	Author/ Publisher	Purpose/Description	Age Range/ Disability	Examiner Qualifications	Other
Psycho-educational Evaluation of the Preschool Child	Jedrysek, Klapper, Pope & Wortis Grune & Stratton 1972	Screening Assesses child's present functioning and level of achievement in following areas: Physical functioning and sensory status, perceptual functioning, comprehension in learning for short-term retention, language comprehension, and cognitive functioning.	CA: 3-6 yrs. MA: 3-6 yrs. Developmental level must be adequate for age. Appropriate for difficult to test children, e.g. emotionally disturbed, behavior problems.	Should be familiar with items, probes, sequences, and materials. Examiner should be able to keep child in control and motivated.	1 Manual Consumable record sheets Materials not provided: 32 common items including toys (listed in manual).
Quick Neurological Screening Test (QNST)	Mutti, Sterling & Spalding Academic Therapy Publications 1978	Screening To identify children with learning disabilities. A total score is obtained by tabulating the scores on the 15 subtests and is judged to be High, Suspicious, or Normal.	Kindergarten (Age 5) through Grade 12 Appropriate for children suspected of being learning disabled.	Psychologist or person in helping profession. Should have administered a minimum of 25 QNSTs for practice and have excellent observation skills.	1 Manual Consumable Recording Forms
Wechsler Preschool and Primary Scale of Intelligence (WPPSI)	Wechsler The Psychological Corporation 1967	Assessment Assesses the intellectual capabilities of the preschol child. The two sub areas of Verbal and Performance are divided into eleven subtests. Raw scores converted to scaled scores and IQ scores.	CA: 2-30 months All disability groups	Should have experience in testing infants of all ages, and be able to effectively interact with infants at various levels of development. Should be thoroughly familiar with the dirctions and scoring procedure.	Test materials complete. Consumable record forms. Materials not provided: 8 common items.

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Missing Test Materials

Environmental Prelanguage Battery (EPB) Manual

Animal Crackers Examiner Manual

Preschool Attainment Record Consumable Record Blanks

Bender Visual Motor Gestalt Test Figure Cards

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APPENDIX G

HIGH RISK INFANTS

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Because of the comparatively recent early intervention movement to prevent mental retardation and other developmental disorders, a whole new population of "high risk" or "at risk" infants has emerged. These children, aged 0-3, are not necessarily handicapped, although the potential for their becoming handicapped is much stronger than the population as a whole. It must be emphasized, however, that these children may not receive special education services in the State of Maryland until such time as they are labeled "handicapped" and placed in a labeled category. It is entirely the decision of the assessment team whether to label a child handicapped, and this is done on an individual case-by-case basis. Our purpose here is simply to discuss the term "high risk", and to offer suggestions for tracking these children, so that special education services can be made immediately available when and if the child ever falls into the category of handicapped.

Categories of Risk

Three categories of risk have been identified by Tjossem (1976):

1) Established risk infants are those whose early aberrant development can be linked to a diagnosed medical disorder with a known cause, and their potential for delayed or abnormal development is well known. Downs syndrome is a classic example of this category. These children are usually identified as handicapped very early in life and receive special educational services.

2) Environmental risk infants are those healthy infants due to low socioeconoic status, poor maternal, family, or health care, or lack of sufficient opportunity for appropriate interpersonal and social interactions. These referrals often come from social welfare agencies.

3) Biological risk infants have a history of prenatal, perinatal, or neonatal events which may cause insult to the central nervous system and subsequently may cause aberrant development. These are often premature or low birthweight infants. Infants who suffer trauma at birth or develop severe medical/surgical problems in infancy also fall into this category. Referrals often come from hospitals or other medical-related agencies.

These categories of risk are not mutually exclusive, and often occur in combination.

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Cautions

- Infant tests are often poor predictors of intellectual status later in early childhood. Additionally, some behaviors are temporarily developmental (e.g. echolalia, neurological soft signs deteced in infancy, etc.) To avoid mistakes in identification a comprehensive assessment must take place which evaluates all areas of the infant's development.
- It is very easy to regard a high-risk infant as certain to be handicapped later. In fact, however, a great majority of these infants will show no later developmental problems whatsoever.

- The reliability and validity of tests are often considered over sensitivity (accuracy in identification of handicap) and cost (proportion of decisions made in error).

Most at-risk infants will end up developing normally. In most cases, it is wise to avoid labeling at this point unless a specific handicap is determined.

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Tracking

Even though these infants may not receive special educational services, it may be beneficial to track them so that outcome may be recorded, and services provided if the child does become handicapped.

Children at environmental risk may be tracked through social and welfare services in most cases. Children at biological risk may be tracked through hospitals or developmental clinics. Pubic health nurses may be able to monitor children of both categories.

It is suggested that local educational agencies set up simple interagency agreements whereby other agencies that are capable of monitoring these high-risk children through their regular procedures or services providing, can refer a child immediately upon suspicion of handicapping conditions to the educational agency for full assessment. Another possibility is for the educational agency to obtain access to other agency records, in order to check them periodically for at risk children who may now be in need of special educational services. These agreements must be made according to the needs and resources of each educational agency.

Summary

Again, the decision whether to label a child handicapped and provide speical educational services remain entirely with the assessment team. High-risk infants who do not become labeled handicapped may not be served by the public schools, but may be referred to other agencies for services and tracking. Biologically high-risk infants are usually already being monitored developmentally. Environmentally high-risk children may be referred to social services agencies for family intervention, or to private or other public intervention programs (e.g. private nursery schools, Head Start, etc.) It is important, however, to monitor these children so that services become immediately available if necessary.

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Summary

Again, the decision whether to label a child handicapped and provide special educational services remains entirely with the assessment team. High-risk infants who do not become labeled handicapped may not be served by the public schools, but may be referred to other agencies for services and tracking. Biologically high risk infants are usually already being monitored developmentally. Environmentally high risk children may be referred to social service agencies for family intervention, or to private or other public intervention programs (e.g. private nursery schools, Head Start, etc.). It is important, however, to monitor these children so that services become immediately available if necessary.

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APPENDIX H

IMPLEMENTATION MATRIX

AREA: I. Child Find Public and Professional Awareness Development

OBJECTIVE: 1.1 To develop and implement a system (model) to build public and professional awareness.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
1.1.1 Identification of SEA personnel as coordinator(s) of the system.						X	-Utilize Child Find Coordinator or identify person to coordinate system for the birth to three population.
1.1.2 Identification of all agencies to be made aware of Child Find and special education services.		X				X	-Continue efforts to identify and inform agencies.

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AREA: I. Child Find Public and Professional Awareness Development

OBJECTIVE: 1.2 . To prepare personnel to conduct public and professional awareness.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
1.2.1 Development of a trainer of trainer model specifying training content.	X			X			-This model will assure consistency and continuity in implementation, but other methods of dissemination of information could be employed (e.g. handbook).
1.2.2 Implementation of New Directions for the Handicapped - Physicians Training Project.	X				X		-Include private physicians in training project as well as physicians from hospitals.
1.2.3. Implement staff development model.	X			X			

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AREA: I. Child Find Public and Professional Awareness Development

OBJECTIVE: 1.3 To develop cooperative liaisons with state agencies involved with populations of young children.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
1.3.1 Identify types of personnel in agencies who will be appropriate for liaison activities.		X			X		
1.3.2. Recommend support from MSDE specialists (graphic arts, public information) to assist in campaign implementation.		X		X			

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AREA: I. Child Find Public and Professional Awareness Development

OBJECTIVE: 1.4 To develop a system (model) for using support services in an effective public and professional awareness campaign.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desire-able	Impor-tant	Critical	
1.4.1 Identify public information resources at state and local levels.		X			X		-LEA Child Find contacts have been designated (coordinator).
1.4.2. Identify and/or produce print and media materials for dissemination with interagency input and participation.		X			X		-Seek more interagency input and participation.
1.4.3. Sharing of produced documents within and among agencies.		X			X		-For example, Child Find brochures and other documents have been sent to other agencies, and other agencies have shared information with MSDE.
1.4.4. Evaluate and revise materials as necessary.		X			X		

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AREA: I. Child Find Public and Professional Awareness Development

OBJECTIVE: 1.5 To evaluate the effectiveness of the public and professional awareness campaign.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
1.5.1. Determine criteria for evaluation.		X				X	-Utilize SSIS system to obtain information. -Determine if information is reaching the proper persons.
1.5.2. Compile data.	X					X	-Survey general public.
1.5.3. Revise procedures as necessary.	X				X		

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AREA: II. Child Find Activities

OBJECTIVE: 2.1 To develop an interagency system (model) to locate children birth to three years for the purpose of identifying those who may be handicapped and in need of special education

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
2.1.1. Pursue interagency cooperation regarding common criteria, use of agency resources, and use of compatible processes.	State level	Local level			X		-Tap into neonatal intensive care nurseries.
2.1.2. Develop interagency liaison(s) network for Child Find activities.	SEA	LEA			X		
2.1.3. Develop procedure to transmit Child Find data among agencies.	SEA	LEA				X	-Establish log of referrals to share with other agencies.

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AREA: II. Child Find Activities

OBJECTIVE: 2.2 To appropriately prepare Child Find personnel.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desire-able	Impor-tant	Critical	
2.2.1. Identify target audience.			X			X	- List is given in plan.
2.2.2. Develop trainer of trainers model.		X			X		
2.2.3. Develop training content.		X				X	
2.2.4. Implement staff development model.		X				X	

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AREA: II. Child Find Activities

OBJECTIVE: 2.3 To evaluate the effectiveness of Child Find Activities.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desirable	Important	Critical	
2.3.1 Determine criteria for evaluation.		X			X		-Measure referrals based on population.
2.3.2. Compile data.		X				X	-Determine how to gather data. -Analyze data.
2.3.3 Revise procedures as necessary.	X				X		

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AREA: III. Screening

OBJECTIVE: 3.1 To develop a system (model) to provide screening of children within the birth to three population who are suspected of having handicapping conditions.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
3.1.1 Recommend personnel to act as coordinator(s) of state level activities related to interagency screening functions.		X				X	-Interagency coordination exists - screening efforts need to be expanded.
3.1.2 Pursue interagency agreements.		X				X	
3.1.3 Recommend guidelines to assist LEAs in coordinating, screening or providing screening services for the birth to three population.		X			X		

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AREA: III. Screening

OBJECTIVE: 3.2 To conduct screening with appropriately trained personnel.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desire-able	Impor-tant	Critical	
3.2.1 Develop a trainer of trainers model.	X				X		-Training already exists at local level-can use to improve quality of screening (will be time and cost effective).
3.2.2 Staff development activities will be implemented.	X				X		

DRAFT

AREA: III. Screening

OBJECTIVE: 3.3 To utilize appropriate screening materials.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
3.3.1 Disseminate guidelines and procedures manual to address administration and direct services needs germane to screening functions.	X				X		
3.3.2 Compile sample instruments and devices for review of LEA's and cooperating agencies.		X		X			-Presently being implemented. -Provide more opportunity to LEAs to use different instruments.

DRAFT

AREA: III. Screening

OBJECTIVE: 3.4 To evaluate the effectiveness of screening activities.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
3.4.1 Determine criteria for evaluation.	X				X		-Percent of those screened who are actually diagnosed and placed. -Criteria may include saving time and money.
3.4.2 Compile data.	X				X		
3.4.3 Revise procedures as necessary.	X				X		

DRAFT

AREA: IV. Assessment

OBJECTIVE: 4.1 To develop a system (model) to provide for assessment of children birth to three years who are suspected of having a handicapping condition and in need of special education.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
4.1.1 Pursue interagency agreements.	X				X		
4.1.2 Recommend guidelines to assist LEAs in coordinating, securing or providing assessment services for the birth to three population.		X			X		-Utilize Protection in Evaluation handbook (MSDE).
4.1.3 Recommend guidelines to assist LEAs in implementing the assessment Process.		X			X		

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AREA: IV. Assessment

OBJECTIVE: 4.2 To develop personnel development activities relative to assessment of the birth to three population.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
4.2.1 Identification of SEA coordinator of inservice training specific to assessment of the birth to three population.	X			X			-LEAs are getting inservice as part of State level initiated training.
4.2.2 Identification of target audience to be trained.		X			X		
4.2.3 Identification of multidisciplinary consultants for assessment of the birth to three population.		X		X			

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AREA: IV. Assessment

OBJECTIVE: 4.2 Continued

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
4.2.4 Utilization of consultants in determining training content and appropriate training format.		X		X			-Have used consultants - continue to do so.
4.2.5 Utilization of appropriate personnel (consultants, MSDE and cooperating agency professionals) in implementing state and local level training.		X			X		-Continue inservice.
4.2.6 Utilization of state evaluation system to determine effectiveness of training at local level.			X		X		-Use State evaluation consistently.

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AREA: IV. Assessment

OBJECTIVE: 4.3 To identify technical assistance resources to assist LEAs and cooperating agencies in providing assessment to the birth to three population.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desirable	Important	Critical	
4.3.1 Early Childhood MSDE specialists will be available to provide regional and/or county based training to personnel involved in assessment activities.			X		X		
4.3.2 A collection of formal and informal assessment devices will be compiled for use in training sessions and for review by LEAs.		X		X			
4.3.3 Guidelines suggesting appropriate use of instruments will be distributed.	X				X		DRAFT
4.3.4 National, regional and local technical assistance resources will be identified.		X			X		

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AREA: IV. Assessment

OBJECTIVE: 4.4 To evaluate the effectiveness of the assessment process.

Action Step	STATUS			IMPORTANCE			Implementation Steps
	Planned	Partially Implem.	Fully Implem.	Desireable	Important	Critical	
4.4.1 Develop criteria for evaluation.	X					X	-Longitudinal studies may be necessary. -Criteria may include whether the placement is appropriate. -Utilize SSIS system.
4.4.2 Compile data.	X					X	
4.4.3 Revise procedures as necessary.	X					X	

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APPENDIX C

CONCEPT PAPER

MARYLAND STATE DEPARTMENT OF EDUCATION
Division of Special Education
200 West Baltimore Street
Baltimore, Maryland 21201

Early Childhood-Special Education Program

CONCEPT PAPER

Maryland has a statutory mandate to serve handicapped children birth through age four who are found to be in need of special education and related services. The following outlines the position of the Maryland State Department of Education, Division of Special Education, relative to services for very young handicapped children.

A. Assumption and Philosophy

In accordance with the mandate for service, the following assumptions are made:

1. Children learn at a very early age:

   Professional literature supports early intervention.

   The handicapped infant needs special help in learning to use his body and in understanding what he sees and hears. Individualized developmental activities may be used to stimulate the child, to explore, and investigate.

   The infant's curiosity can be used to encourage learning and development.

2. The parent is the primary teacher for the infant:

   Parents are the focus of the delivery of special education services for infants since they are in a position to foster experiences which are a part of the infant's life at home and with his/her family in a variety of settings. Therefore, it is our premise that the best approach is to provide training and assistance to the parent or other caregivers.

In Maryland, the legislation provides the opportunity for handicapped infants to receive full appropriate education. The services provided in occurrence with the statuatory mandate are directed specifically toward children who are determined through appropriate assessment as having special education needs. Special education services are designed for children identified as handicapped in the 11 areas identified in Bylaw 13.04.01. The provision assumes:

a. that all handicapped children are able to learn in some way,

b. that a handicapped infant needs specialized intervention to maximize self sufficiency,

c. that parents and other caregivers are entitled to supportive and specialized educational services, and

d. that a portion of the total cost of an early childhood program may be recovered from the savings which result as participating students progress through schools requiring less costly forms of education.

B. Types of Services

Three models may be used to deliver services to handicapped children from birth to age four - home based, center based and a combination of home and center based.

Home Based Instruction

Home instruction provides intensive one-to-one teaching of parent and child in the most natural and least restrictive environment. Teaching methods and materials are tailored to fit a child's learning style, activity level, and attention span in harmony with his/her daily routine.

Home instruction involves a teacher who sees families, perhaps as often as twice a week. The special education teacher may serve as the leader of a multidisciplinary team of practitioners which may include an occupational or physical therapist, speech-language pathologist, nurse, social worker, or aide.

According to Shear (1976), the educational advantages to home based services are:

1. Learning occurs in the parent and child's natural environment.
2. There is direct and constant access to behaviors as they occur naturally.
3. It is more likely that learned behavior will generalize and be maintained if the behaviors have been learned in the child's home environment and taught by the child's natural reinforcing agent, parents.
4. When instruction occurs in the home, there is more opportunity for full family participation in the teaching process.
5. There is access to the full range of behaviors, many of which could not be target for modification within a classroom.

6. It is hypothesized that the training of parents, who already are natural reinforcing agents, will provide them with skills necessary to deal with new behaviors when they occur.

7. Individualization of instructional goals for both (parent and child) is a ... reality. (pgs. 336-337).

Center Based Instruction

The design most frequently used involves several learning stations where parent(s), child, teacher, and therapist or aide work with the child on selected developmental activities. These developmental activities may focus on motor, communication or, cognitive learning.

Because parents meet regularly within a group, this design is likely to foster relationships among parents and facilitate both informal and structured discussion of common problems and solutions.

For the older handicapped preschooler, this design "affords an opportunity for the child to have a variety of contacts with peers and the staff" (Connor, 1978) and promotes the development of socialization skills.

Home and Center Based Instruction

This design combines the above approaches. Children may be seen in the home and in the center. A combination home and center based model offers flexibility in meeting parent and child needs.

C. Consideration for Developing the Individualized Educational Program

Early intervention is based on the premise that the parent, as the first and most natural teacher of the young child, should continue in this role and that professionals can help parents to teach their handicapped child effectively. Consequently, successful early childhood education results from successful parent education.

The Admission, Review, and Dismissal Committee has the responsibility for developing an IEP for each handicapped child. Although the IEP generally focuses on the child's educational and therapeutic goals and objectives, both parent and child needs should be considered when selecting the format and content of service delivery.

Hands-on services by professionals on a daily basis is not considered necessary or optimal for the efficacy of early intervention. Exemplary programs federally funded for outreach and replication generally provide one - two family contacts each week with home visits or center sessions lasting one - three hours.

Early intervention programs conducted in Maryland generally follow a similar pattern of regularly scheduled sessions.

General considerations for the determination of the type of services include:

1. Commitment to the philosophy of providing appropriate training to the parent without assuming the parent's natural teaching and caregiving role.
2. A guiding principle in effective early intervention techniques is to incorporate educational techniques into the routine activities of daily living, assuring frequent repetition in a natural setting.

The ARD committee should consider increasing or diminishing frequency of services on an individual basis, based upon the child's needs and parents' schedule.

D. Transportation

Transportation of handicapped preschoolers shall be in accordance with Bylaw 13.04.01.03H.

APPENDIX D

Interagency Agreement: Maryland State Department of Education and Maryland State Department of Health and Mental Hygiene

INTERAGENCY AGREEMENT

Cooperative Agreement between the Maryland State Department of Education, Division of Special Education, and the Maryland State Department of Health and Mental Hygiene, Crippled Children's Services, S.S.I. Disabled Children's Program.

April 1, 1981

I. Rationale

There are a variety of federal and state mandates which require the cooperative delivery of services to handicapped individuals.

P.L. 94-142, Section 121a.301, states that each state may use whatever state, local, federal, and private sources of support are available in the state to meet the requirements of a free appropriate public education.

P. L. 94-566, Section 51a.309 requires cooperative agreements among state agencies which provide services to disabled children. The purpose of the cooperative agreement is to assure that services under the plan are coordinated with all responsible agencies providing services to disabled children and that all reasonable efforts are made to use existing services and to obtain financial support from these agencies.

Maryland Bylaw 13.04.01.03D states that the State Department of Education, in collaboration with other state agencies, shall establish, implement, and maintain state interagency coordination to insure the development of interagency planning and implementation of programs for handicapped children.

In Maryland, the State Coordinating Committee on Services to the Handicapped was established in June 1978. One of the Committee charges was "to coordinate its efforts with all state agencies and Departments serving the handicapped children of this state."

II. Statement of Issue

The Maryland State Department of Education is the designated state agency responsible under P.L. 94-142, Maryland Education Article 8.401, and Maryland Bylaw 13.04.01 for assuring that all handicapped children birth through 20, receive a free and appropriate education and that each child has an individualized education program appropriate to the child's special education needs.

The Maryland State Department of Health and Mental Hygiene, Crippled Children's Services is the designated state agency responsible for implementing the provisions of the Supplemental, Security Income-Disabled Children's Program (SSI) under Title XVI of the Social Security Act. Referrals of blind or disabled children under the age of sixteen (16) are made by the Social Security Administration to the State Agency administering the SSI/DCP. It is the responsibility of the Supplemental Security Income-Disabled Children's Program to provide an Individual Service Plan (ISP) to meet the comprehensive needs of the child receiving SSI benefits under the age of 16. The Supplemental Security Income-Disabled Children's Program is responsible for the administration of a State Plan which provides for counseling, establishing and monitoring of individual service plans, referrals for disabled children under 16 years of age, and the provision of medical, social, developmental, and rehabilitative services for disabled children under seven years of age, as well as for those children 7-16 years who have never attended public school.

III. Purposes of the Agreement

It is the intent of this agreement to: (1) specify each agency's responsibility to the handicapped individual; (2) delineate those services to be provided by each agency; (3) define the process whereby each agency assumes the financial responsibility for providing the service to the individual; (4) provide a mechanism for an uninterrupted flow of services to the individual as indicated in both the individualized education plan (IEP) developed by education (including therapy services), and in the Individual Service Plan developed by the SSI-Disabled Children's Program; (5) provide a system for joint planning at the local level to insure that all resources will be utilized in an effective manner; (6) attempt to eliminate the duplication of services; and (7) establish and maintain channels of communication and coordination at the state level and provide a mechanism for collaboration at the local level.

A. Referrals

Referrals to both agencies shall be a combined responsibility. The Department of Education (through local school systems) and the SSI/DCP will refer those disabled children to the appropriate agency/resource for supportive services.

1. Referrals to SSI/DCP

   A. All referrals from an educational agency should be for disabled children age 0-16 years of age who are receiving SSI benefits.

   B. Referrals should be made to the appropriate case manager (see attachment) of the SSI/DCP according to the child's geographical location (home) with information related back to the school system indicating additional services and case status.

   C. SSI/DCP will have form for referral (see attachment).

2. Referrals to Department of Education

   A. Referrals to an educational agency for special education services should be coordinated through the local Child/Find Coordinator or administrator for special education with feedback from the Local Child Find Coordinator to the SSI/DCP case manager indicating follow-up services, school placement, etc.

   B. Referrals will be accepted for those children age 0 through 20 years of age.

   C. Referrals may also be made to the State Child Find Hotline 383-6523.

B. Exchange of Information

The exchange of information between the Department of Education, local education agencies, and SSI/DCP shall be mutual. It is expected that information concerning clients will be exchanged for professional use with appropriate safeguards to protect its confidential nature. Signed consent for referral by a parent or guardian shall be required by both agencies for all dependent children. Primary responsibility for obtaining the necessary release of information will be that of the referring agency.

1. The exchange of the Individualized Education Plan (IEP) and the Individual Service Plan (ISP) shall be automatic (with signed parental consent) and free flowing for those persons from both agencies working with the child and participating in the development of the plans.
2. The SSI/DCP program director will identify monthly by county to the Department of Education those children who are SSI recipients with signed parent consent. This information will be sent to LEA Special Education Supervisor.
3. Any new evaluations or assessments done by the LEA for the SSI child should be sent to the case manager. Responsibility for any costs for duplication will be mutually determined by the SSI/DCP case manager and the LEA designee. All evaluations obtained by the SSI/DCP case manager pertinent to the educational needs of the child will be sent to the local supervisor of special education, with signed parental consent.
4. Only that information which is originated by the two agencies will be released.

C. Development of Individual Service Plans and Individualized Education Plans

Both the ISP and the IEP are to be written and based upon a multi-disciplinary assessment of the child's needs and strengths. Every effort should be made to insure that a representative from both agencies participates in the planning of the IEP and ISP. This is consistent with the multi-disciplinary team approach in the SSI/DCP and the Admission, Review, and Dismissal Committee (ARD) in the local education agencies.

1. The SSI/DCP case manager will be included in the planning of the IEP, the annual review of the IEP, and the re-evaluation of the IEP for those SSI recipients known to SSI/DCP.
2. Local education personnel (designated by the special education supervisor) will be included in the planning and development of the ISP.
3. In those cases where LEAs have developed an IEP which meets the content requirement and is appropriate to the needs of the ISP, the IEP will be incorporated into the ISP.
4. Whenever a significant event occurs with the client, that will interfere with the objectives written in the IEP or ISP, there will be a cooperative exchange of relevant reports originated by the agencies, with signed parental consent.

D. Provision of Services

1. SSI/DCP

According to the Public Law 94-566 with funds made available under said Act, the SSI/DCP is mandated to provide for counseling, development of individual service plans, and referral for disabled children under 16 years of age, and provides medical, social, developmental and rehabilitative services for disabled children under 7 years of age and those who have never attended public school. However, the program is also mandated to explore and utilize services provided by other federal, state and local agencies, and community resources before utilizing SSI/DCP funds. When all other resources legally mandated to provide services to SSI children 0-7 years have been utilized or are not available, the SSI/DCP may provide the required services needed to carry out the objectives set forth in the child's individual service plan.

Public Law 94-566 mandates that SSI/DCP funds can be spent to purchase services only for those children age 0-6 years of age or those children 7-16 years of age who have never attended public school, provided no other agency is mandated to provide the service. Services can continue beyond the age of six or beyond the termination from SSI, if abrupt termination of services would be contrary to good medical practice.

The following services may be provided to blind and disabled children receiving SSI benefits: (Services may include but are not limited to the following:)

a. Preventive, diagnostic, and treatment services of a physician and, as appropriate, physician extenders;

b. In-patient and out-patient hospital services;

c. Dental services;

d. Nursing services;

e. Home health services;

f. Social services;

g. Rehabilitative services including long-term and short-term physical and occupational therapy;

h. Speech and hearing services;

i. Vision services;

j. Child development services;

k. Mental health services;

l. Counseling services including rehabilitative, developmental, social, occupational, and educational counseling;

m. Allied health services;

n. Pharmaceutical services including the provision of drugs;

o. Medical device and related services;

p. Transportation services needed to carry out the individual service plan;

q. Emergency medical services;

r. Nutrition services as needed to assist in carrying out the individual service plan;

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s. Reading and interpreter services for the deaf and blind; and

t. Other services necessary to assist in carrying out the individual service plan.

2. Department of Education

Public Law 94-142 mandates that the State Department of Education have in effect policies which insure that all handicapped children have the right to a free appropriate public education. All children who are handicapped, regardless of the severity of their handicap, and who are in need of special education and related services must be identified, located, evaluated and provided an appropriate program of special education and related services to meet their individual needs. Related services may include transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education and includes the early identification and assessment of handicapping conditions in children.

P. L. 94-142 makes a number of critical stipulations which must be adhered to by both the state and its localities. These stipulations include:

- assurance of extensive child identification procedures;
- assurance of "full service" goal and detailed timetable;
- a guarantee of complete due process procedures;
- the assurance of regular parent or guardian consultation;
- maintenance of programs and procedures for comprehensive personnel development including inservice training;
- assurance of special education being provided to all handicapped children in the "least restrictive" environment;
- assurance of procedures which insure nondiscriminatory testing and evaluation;
- a guarantee of policies and procedures to protect the confidentiality of data and information;
- assurance of the maintenance of an individualized education program (IEP) for all handicapped children;
- assurance of an effective policy guaranteeing the right of all handicapped children to a free, appropriate public education, at no cost to parents or guardians;
- assurance of procedures to provide a surrogate to act for any child whose parents or guardians are either unknown or unavailable, or when said child is a legal ward of the state.

IV. Liaison Representatives

A. State

The administrators or their designees of the respective agencies will insure time and staff necessary to insure appropriate liaison for implementation of this agreement. The state liaison representative in the SSI/DCP will be the program director. In the Department of Education, the liaison will be the interagency specialist and the regional administrators.

B. Local

In the SSI/DCP, the liaison will be the case managers. In the local education system, the liaison will be the LEA special education supervisors or their designee.

V. State Plans

The Maryland State Department of Education and the Supplemental Security Income - Disabled Children's Program unit agree to exchange copies of their approved State Plan and to keep the other agency informed as to pertinent changes that would affect interagency cooperation.

Each agency will be familiar with and responsible for interpreting, when appropriate, the intent of the other state agencies program to people at various levels as they work cooperatively to integrate the two programs.

VI. Review of this Agreement

At least annually, there will be a renewal of this agreement by the state liaison representatives of the two agencies to update, review, and revise services as needed. At these meetings, problems, including financial responsibility, may be identified, issues discussed, and problems resolved. Amendments can be made by mutual agreement. Annual reports will be provided to appropriate personnel in both agencies. The components of this agreement will be reviewed with new personnel in both agencies to assure awareness and to fulfill the terms of this agreement on an ongoing basis.

CHARLES R. BUCK, Jr., Secretary
Department of Health & Mental Hygiene

DAVID W. HORNBECK
Superintendent of Schools
Department of Education

Judson F. Force, M.D., M.P.A.
Director
Developmental Disabilities Administration

Martha J. Irvin
Assistant State Superintendent
Division of Special Education